An Exploration of the Role of the Therapeutic Relationship in the Treatment of Complex Trauma: A Psychodynamic-Phenomenological Case Study

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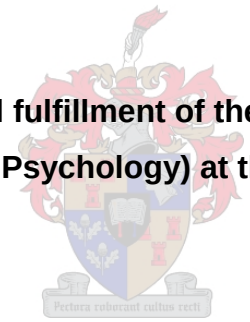

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STATEMENT

I, the undersigned, hereby declare that the work contained in this thesis is my own original work, and that I have not previously in its entirety or in part submitted it at any university for a degree.

…… 21 January, 2008

Signature **Date**

ABSTRACT

Sometimes it is not entirely clear why certain clients improve. Critical clinical ingredients which may have led to this improvement or recovery are hard to identify and describe and decisions about therapeutic interventions often appear to be intuitive rather than following a strict *modus operandi*. This is true particularly if refractory or chronic cases start to improve and maintain this improvement.

Refractory and chronic cases are the norm amongst clients suffering from complex, chronic trauma, also termed complex PTSD. Complex trauma is a multi-facetted, often multi-layered condition. It includes damage to the individuals' *self* and to her *ability to interpersonally relate*, additionally to the DSM IV TR diagnosis of PTSD. Due to the manifold unique presentations of the syndrome, particular after long-term exposure and confounded by co-morbidities and rigid defenses, it is difficult to diagnose and treat the condition effectively.

This study focuses on one such complex trauma case with an initially very poor prognosis, which improved significantly over a treatment period of eighteen months. The therapeutic intervention and progression of the case are closely examined, using the phenomenological method, with the aim of discerning and describing themes and patterns that could assist in understanding the healing process of this client during therapy and to promote further research in this regard.

Integration of psychodynamic conceptualization, particularly self-psychology and intersubjectivity, and person-centered, supportive therapeutic methods were found helpful in the treatment of this case. The common factor to these approaches is their emphasis on the relationship between client and therapist. This therapeutic relationship was concluded to be the determining factor in the successful treatment of this client, because it addressed damage to self and to her relational ability.

The research took place concurrent to the therapy with the client and this process led to a degree of integration on three levels: integration of the client's self and interpersonal functioning, integration of the abovementioned approaches to form a creative synthesis

in the therapist's individual approach to trauma clients, and the integration of a phenomenological methodology with a psychodynamically conceptualized case study.

It is noted that the theoretical explorations and therapeutic procedures described and explored in this study are but one way to conceptualize and treat complex trauma.

OPSOMMING

Somtyds is dit nie duidelik hoekom sekere kliente se toestand verbeter nie. Dit is soms moeilik om die kritiese bestanddele wat tot hierdie verbetering of herstel gelei het, te identifiseer en te beskryf. Besluite met betrekking op therapeutiese intervensies blyk dikwels eerder intuitief, as die gevolg van ‘n streng *modus operandi,* te wees. Dit is spesifiek die geval wanneer chroniese en hardnekkige gevalle begin om te verbeter en die verbetering volhou.

Hardnekkige en chroniese gevalle is nie ongewoon by kliente wat aan komplekse, chroniese trauma - ook genoem komplekse post-traumatiese stressversteuring - ly nie. Komplekse trauma is ‘n multi-fasettige toestand, wat dikwels ‘n verskeidenheid lae of vlakke van versteuring opwys. Dit sluit skade tot die individu se *self* in, asook verlies aan vaardigheid om met ander mense suksesvolle interpersoonlike verhoudings op te bou. Hierdie kenmerke is toevoegings tot die diagnose van die sindroom soos uitgevoer in die DSM IV TR. As gevolg van die meervoudige unieke voorstellings van die sindroom - in besonder na langtermyn blootstelling en verwarring deur co-ongesteldhede en rigiede verdedigings - is dit moeilik om die toestand korrek te diagnoseer en efektief te behandel.

Hierdie studie fokus op die soort geval wat aanvanklik ‘n baie swak prognose gehad het, maar vervolgens oor ‘n tydperk van 18 maande ‘n beduidende verbetering getoon het. Die terapeutiese intervensie en die progressie van die geval is in hierdie studie noukeurig ondersoek, deur gebruik te maak van fenomenologiese ondersoekmetodes, met die doel om temas en patrone vas te stel en te beskryf wat die begrip van die genesingsproses van die klient gedurende terapie moontlik kan bevorder, en wat verdere navorsing op hierdie gebied kan stimuleer.

Integrasie van psigodinamiese konseptualisering (spesifiek self-sielkunde en intersubjektiwiteit) asook persoongesentreerde, ondersteunende beradingsmetodes, is as waardevol bevind in die behandeling van hierdie geval . Die gemeenskaplike faktor tot hierdie benaderings is die klem op die verhouding tussen klient and terapeut. Die gevolgtrekking is gemaak dat hierdie terapeutiese verhouding die bepalende faktor in die

sukkesvolle behandeling van hierdie klient was, omdat dit sowel die skade aan die *self* as die verlies aan die vaardigheid om verhoudings te bou, aangespreek het.

Die navorsing en die terapeutiese intervensie met die klient het terselftertyd plaasgevind, en die proses het ten slotte tot ‘n mate van integrasie op drie vlakke gelei: integrasie van die klient se *self* en herstelling van interpersoonlike funksionering, integrasie van die bo-genoemde benaderings wat tot ‘n kreatiewe sintese in die berader se benadering tot trauma behandeling gelei het, en die integrasie van fenomenologiese metodes en psigodinamies konseptualisering in ‘n gevallestudie.

Dit is belangrik om in gedagte te hou dat die teoretiese navorsing en praktiese prosedures wat in hierdie studie beskryf en uiteengesit is, net een manier is om komplekse trauma te konseptualiseer en te behandel.

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The biggest thank you goes to the client who with her kind permission and enthusiastic cooperation made this paper possible.

Note to the reader: As it is cumbersome to write “he or she” all the time if one wants to avoid using the male singular pronoun to refer to both sexes (particularly in the non-case-specific sections of the paper) I have tried to alternate the use of he and she in a balanced way throughout the text.

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“Do not go gentle into that good night
Rage, rage against the dying of the light.”
(Dylan Thomas)

“Es kommt darauf an das Hoffen zu lernen.”
(Ernst Bloch)

1. Introduction and Motivation

Introduction

Complex trauma (Herman, 1992) is an individually unique, multi-facetted, multi-layered condition, which is often hard to diagnose, difficult and time-consuming to treat, and frequently refractory (Herman, 1992, 1999; Lindy & Wilson, 2001; Pearlman, 2001; Taylor, 1998; van der Kolk, 1996). Complex trauma differs from and exceeds the diagnostic criteria of Post-Traumatic Stress Disorder (PTSD) found in the Diagnostic and Statistical Manual of Mental Disorders IV TR (2000). It is characterised by damage to the self (identity / personality) and damage to the ability to interpersonally relate, in addition to the DSM-IV-TR (2000) PTSD symptoms of hyperarousal, avoidance / numbing, and intrusive memories (Herman, 1992, 1999; Wilson, Friedman & Lindy, 2001). This is due to the chronic and repetitive nature of complex trauma, which frequently commences in the formative years and so damages or malforms personality and inhibits, disrupts, or prevents achievement of developmental milestones (Herman, 1992; Terr, 1999), which leads to the above symptomatology with additional comorbidities, such as substance abuse and addictions (McFarlane, 2001), dissociation (Putnam, 1999; Spiegel, Hunt & Dondershine, 1999), affect dysregulation (van der Kolk, 1996), somatisation, and treatment resistant depression (Herman, 1992).

Cognitive-behavioural PTSD treatments that are highly effective with sufferers of once-off trauma (Foa & Cahill, 2002; Zoellner, Fitzgibbons & Foa, 2001), frequently do not suffice to heal clients with a history of chronic trauma, due to the individuality and complexity of the syndrome, the lack of personality integration due to damage of the self-structure, and the difficulty in identifying and diagnosing the condition, which often presents as a personality disorder or traits thereof (Herman, 1992; Putnam, 1999; Terr, 1999; Wilson et al., 2001). Psycho-dynamic conceptualisation, combined with appropriate techniques of other approaches, appears to be the most promising therapeutic approach to these often chronic and refractory cases (Herman, 1992; Pearlman, 1996; van der Kolk, 2002; Wilson et al., 2001). Person-centred supportive therapeutic techniques, in conjunction with sound psycho-dynamic understanding, play an important practical role particularly during the first phase of treatment when support and safety rather than exploration is the focus of intervention (Holmes, 1995; Werman, 1989). The therapeutic potential of appropriate synthesis of different approaches has been well documented in both Yalom (1980) and Brammer, Abrego, and Shostrom (1993).

Psycho-dynamic understanding grounded in self-psychology theory (Kohut, 1972; Kohut & Wolf, 1978) and intersubjectivity theory (Atwood & Stolorow, 1994) are well suited to conceptualising as well as treating complex trauma due to their compatibility (Trop, 1995) and their emphasis on relational aspects in therapy, which addresses the core areas of damage in complex trauma patients, that is the damaged self and the inability to establish and maintain healthy, intimate, interpersonal relations.

Self-psychology as well as intersubjectivity both place great emphasis on the therapeutic relationship, transference / countertransference, and empathic attunement between therapist and client (Trop, 1995). Yet the application and understanding of these phenomena differs somewhat. Self-psychology advocates a more supportive kind of therapy, with the therapist as self-object and provider of stability, empathy and confirmation of the client's self to enable him to move from fragmentation to integration. This supportive, non-interpretive technique is particularly important and appropriate during the first stages of therapy, when the client's self is fragmented and the presentation in therapy is possibly quite non-verbal, that is re-enacting rather than

verbalising (Garland, 1998; Wilson & Lindy, 1994) and requires implementation of techniques found in supportive therapy (Holmes, 1995; Werman, 1989) as well as person-centred therapy (Grobler, Schenck & du Toit, 2003; Mearns & Thorne, 1988; Rogers, 1980).

Intersubjectivity advocates significantly more client participation, such as the cooperative investigation of patterns and organising models in the client's life and the use of empathic misattunements as opportunities for growth rather than mishaps to be avoided. This approach is well-suited for later phases of therapy when the client has stabilised, the self has acquired more vitality and some empowerment has taken place for the client to feel a sense of agency so as to contend with anxiety provoking memories, events, and fantasies without disintegrating (van der Kolk, 2007). This approach similarly employs techniques described first in person-centred therapy by Rogers (1980) and Mearns and Thorne (1988), such as permitting the client to lead and to leave much responsibility for therapeutic content, direction, and speed with the client, rather than doing this work for him.

These approaches illustrate that a significant aspect of psycho-dynamic treatments is the mutual relatedness of client and therapist in the therapeutic situation. It is in fact an important diagnostic and treatment tool (Herman, 1992; Holmes, 1995; Knight, 2005; Wilson & Lindy, 1994), for example via self-object transference (Kohut & Wolf, 1978) and the mutual exploration and creation of organising principles or patterns in peoples' lives (Atwood & Stolorow, 1984). However, this relationship, which at the best of times impacts positively on the client to effect healing, also has the potential to cause great distress and a variety of intense emotional reactions in the therapist. Transference and countertransference are of a particularly difficult nature and of high intensity when working with trauma survivors; and to deal with it, the therapist requires great self-awareness, endurance and excellent supervision (Herman, 1992; Klain & Paviae, 1999; Wilson & Lindy, 1994; Wilson et al., 2001).

Healing of such intense and deep-seated injury is a slow process that moves through distinct phases. Herman (1992) conceptualises the healing process as a three phase therapeutic model, moving from 1) safety, to 2) remembrance and mourning, to 3)

reconnection. This shall serve as the structure for the unpacking of the therapeutic intervention explored in this case study.

A case study will be used to explore the role of the therapeutic relationship in a phased healing process of a client suffering from complex trauma, utilising self-psychology and intersubjectivity theory to unpack the role of the therapeutic relationship and its dynamics in the healing process. It is essential to note that the therapist embarked on this therapeutic journey with the client with limited knowledge about trauma treatments, and that this led to the focus on the therapeutic relationship based on her humanist philosophical worldview, expressed via a supportive, person-centred therapeutic approach, which shares a number of integral concepts with both self-psychology and intersubjectivity (Tobin, 1991). The theoretical exploration and positioning of the case occurred parallel to therapy as well as on reflection on the case after completion of therapy. The case study method was deemed appropriate for the complexity and uniqueness of a complex trauma case such as this one, permitting in-depth exploration of the dynamics of the therapeutic process and highlighting the shifts that took place in both the client's psyche as well as the therapist's theoretical understanding and therapeutic approach.

1.2 Motivation: Relevance of the Research

Trauma, neglect and violence against women and children are endemic in South Africa (Robertson, 1998; Children's Institute UCT, 2003) and internationally (van der Kolk, 2002). Trauma occurs on all levels of society including seemingly 'normal' middle class homes (Pearlman, 2001), though the prevalence is higher amongst less privileged groups of the population (Children's Institute UCT, 2003; Shalev, 1996). The high level of violence against women and children is exacerbated by the high prevalence of violent crime as well as a still deeply patriarchal society in South Africa, where children and women are often considered a man's "property" and not individuals in their own right (Deputy President's Address, March 2007; President's Address, August 2007; Robertson, 1998). This in turn increases the potential for chronic traumatic long-term neglect, abuse, and witnessing of violence, with onset in childhood and later re-victimizations (Herman, 1992, 1999; Terr, 1999; van der Kolk, 1996, 2002). Traumatic experiences often occur within the family context, at an early age, and on a continuous

basis with few alternative non-abusive adult role models or life-styles. According to South African statistics cited by Conradie (2003), more than 90% of abused children are violated by perpetrators they know. Due to lack of defenses and alternatives in childhood, children become victims and often remain victims because they have neither seen nor learnt different ways of acting or coping, and the personality malformed by trauma is the sole structure available for reacting to events and interpretation thereof.

Aggression, suicidality, interpersonal and emotional disconnectedness are integral parts of the symptom cluster presenting as complex trauma (Herman, 1992; Masterson, 1988; Terr, 1999; van der Kolk, 1996) and if left untreated, have long-term effects for the sufferers own life, their families, community, and society at large. It is also not unusual for the adult survivor to turn into a perpetrator later in life, so as to gratify an unmet need for control, agency, and anger-release, once physical strength and life circumstances have placed him in a position to victimize others, for example their own children (Miller, 1980, 1987, 1990, 1995; van der Kolk & McFarlane, 1996). This spiral of violence and inter-generational trauma transfer needs to be addressed, and healing needs to be initiated on an individual as well as societal level, to prevent it from taking root in every new generation (Herman, 1992; Masterson, 1988).

The psychologist confronted with an adult survivor of chronic or complex trauma might not immediately recognize this. Complex trauma, also termed complex PTSD (Wilson et al., 2001; Pearlman, 2001) is currently not listed as a diagnosable entity in the DSM-IV-TR (2000), only as Disorder of Extreme Stress Not Otherwise Specified (DESNOS) and not explicitly taught, despite being endemic in South Africa. Complex trauma in adults mostly presents in a covert manner, in form of personality disorders or traits thereof, somatization, addictions, depression, aggression, and difficulties in establishing and maintaining relationships (Herman, 1992; McFarlane, 2001; Pearlman, 1996; Terr, 1999; van der Kolk & McFarlane, 1996; Wilson et al., 2001), with the trauma often not stated as presenting problem or reason for referral. Due to the great variety of presenting problems and symptom clusters, complex trauma is often misdiagnosed (Herman, 1992; Wilson et al., 2001). Therefore, treatment may be delayed, minimal, or mere symptom treatment, which does not address the underlying causative trauma. Such lack of intervention maintains and exacerbates the syndrome and the result is a continued

experience of low quality of life for sufferers, with little or no future orientation, and severe negative impact on family members and community.

Due to gravity and widespread reality of complex trauma, the its variability of presentation, frequent late diagnosis and treatment, and high prevalence of refractory cases, there is an ongoing need to explore novel or modified treatment options, particularly with regards to chronic, treatment resistant cases. Sometimes therapy results in healing and growth in individuals who have been suffering unremittingly for a long time and whose prognosis was poor, but the causative explanation for such improvement seems illusive due to therapeutic intervention having been based more on the therapist's 'instinct' rather than a clear theoretical approach (Yalom, 1980). It is important to explore such cases in details, in an attempt to identify factors that may have contributed to healing, and to attempt to formalize these into an integrated approach that can be replicated.

The phenomenological exploration of the case in theoretical as in therapeutic terms proceeds hand in hand not only with identification of concepts and practices from theories and approaches utilized, but also attempts to describe how these were creatively combined and synthesized into this junior therapist's unique way of counseling. This creative synthesis approach "strives to integrate in incremental fashion what appear to be separate ideas and uncoordinated methods" (Brammer, Abrego & Shostrom, 1993) and in this way to further individual development of the therapist as well as theory-building. In this case, the integration of methods and theories by the therapist and the increasing integration of the client are described and explored concurrently. In this way the paper also endeavours to contribute to, and to encourage further research in the treatment of complex trauma.

In summary, the main goal of the research is the phenomenological investigation of the treatment of complex and chronic trauma using psychodynamic conceptualization and therapy, adding person-centered methods, and to critically discuss the emerging phenomena with regards to growth and integration in client, therapist and theory-building, as the therapeutic process unfolds.

2. Literature Review

This section provides a conceptualization of the term complex trauma, and introduces and summarizes the theoretical approaches, which are employed in the discussion section to explore the patterns and dynamics of the therapeutic process.

The case was initially approached from a humanistic, person-centered perspective due to the relative inexperience in the areas of trauma diagnosis, trauma treatment, and psychodynamic approaches. Throughout the duration of the treatment, concurrent literature study and supervision introduced the psychodynamic approaches of self-psychology and intersubjectivity, as well as the concepts of complex trauma and supportive therapy, which assisted the therapist in conceptualizing the case more and more succinctly and to note the emerging patterns and dynamics in the therapeutic relationship, which remained the primary tool of intervention.

Therefore, these approaches are used to describe and tentatively interpret the therapeutic relationship dynamics between client and therapist in this case, keeping in mind that the researcher hypothesized that the relationship was the major contributory factor to the client's recovery. This method of concurrent therapeutic intervention and immersion in / discovery of relevant theory represents a much simplified version of Rogers' theory development built on therapeutic experience, as described in Möller (1995), and is in line with the creative synthesis approach as outlined by Brammer et al. (1993).

Conceptualization of Complex Trauma

Herman (1992) established the term "complex trauma", which is embedded in both the medical model (employing diagnosis and psychiatric/medical terminology) as well as the psychodynamic approach. Herman conceptualizes complex trauma as a syndrome characterized by alterations in affect regulation, consciousness, self-perception, perception of the perpetrator, relations with others, and one's systems of meanings. For the purpose of this paper the terms complex trauma and complex PTSD are used interchangeably, both indicating the psychological effects of chronic, prolonged or multiple event trauma on the individual.

Complex trauma is caused by multiple or ongoing traumatic events, including sustained neglect in the formative years (Chemtob & Taylor, 2002; Herman, 1992; Kohut & Wolf, 1978; McFarlane & Girolamo, 1996; Nader, 2001; Terr 1999). Though multiple traumatic experiences are not uncommon amongst South African adults (Kistner, 2004), chronic trauma with childhood onset will be the focus in this study. Chronic or repetitive trauma results in particular features in affected children: denial and psychic numbing, self-hypnosis and dissociation, as well as inward and outward directed rage (Terr, 1999). Continuous and repeated exposure to traumatic events leads to delay, regression, or inability to the master developmental milestones of psychological maturation, such as trust, autonomy, initiative, competence, identity and intimacy (Erikson, 1968).

Herman (1992) argues that continuous, chronic trauma leads to a loss of self, which often results in tenacious symptoms of depression and deforms personality. The fragmentation which the individual's self experiences, becomes the central principle of personality organization and results in a disjointed, borderline-like personality presentation (Herman, 1999; Terr, 1999; Masterson, 1988; van der Kolk, 2002;), which might already become noticeable in childhood or adolescence (Lewis & Volkmar, 2000). Coping mechanisms and defenses are formed, used consistently, become rigid and cement the personality malformation (Pearlman, 1996; van der Kolk 1996, Terr 1996, Herman 1992, Wilson et al., 2001). The person becomes increasingly disempowered, disconnected and isolated, which may exacerbate existential dilemmas regarding the meaning of life itself and may lead to extreme hopelessness with sharply increased suicidality (Herman, 1992). The fragmentation of self limits the ability to establish and maintain supportive interpersonal relations, to establish healthy attachment and intimacy (Masterson, 1988).

Perceptual distortions with regards to self, affect, external events and physical / neurological events are a common feature of multiply traumatized individuals (Herman, 1992; Pearlman, 1996). The survivor consciously and unconsciously uses mind-altering and reality-altering, such as depersonalization, derealization, and dissociation (Putnam, 1999), even Multiple Personality Disorder (Herman, 1999; Terr, 1999) as coping strategies to ward off or make bearable the "survivor triad" of insomnia, nightmares, and psychosomatic complaints (Herman, 1992). Additional features commonly found in

complex trauma clients are eating disorders and substance abuse (McFarlane, 2001), attachment problems (Herman, 1992; Garland 1998; van der Kolk, 1996), affect dysregulation and self-mutilation (van der Kolk, 1996, 2002) and alexithymia (McFarlane, Golier & Yehuda, 2002; van der Kolk & McFarlane, 1996; van der Kolk, 1996). Research is divided regarding these conditions either being considered comorbidities (McFarlane, 2001; Yehuda & McFarlane, 1999) or rather (integral) parts of the complex trauma syndrome as argued explicitly by Herman (1992) and implicitly by Wilson et al. (2001). These conceptualizations have implications for treatment, which could proceed either concurrent or sequential.

Wilson et al. (2001) summarized the wealth of information and conceptualizations regarding presentations of trauma reactions by clarifying, exploring and cataloguing no less than "65 total symptoms, 13 for each cluster: (1) traumatic memory, (2) avoidance / numbing, (3) psychobiological alterations, (4) impact on ego states, and (5) interpersonal relations" (p.53). This conceptualization differs from the DSM-IV-TR PTSD triad by adding *damage to self* and *damage to ability to relate interpersonally* to the "pure", more medically focused, PTSD symptom cluster of hyperarousal, intrusive memories and avoidance / numbing, which was largely based on Kardiner's medical / psychiatric definition of war neuroses (Cited in Lindy, 1996; and in Herman, 1992).

Ameliorating factors, which to a larger or lesser extent safeguard an individual from a traumatic reaction are a good support system (sociability), an internal locus of control, and active, task-oriented coping strategies (Herman, 1992; Yehuda & McFarlane, 1999). Exacerbating factors are traumata that are caused by humans (as opposed to natural disasters), the presence of deliberate malice, the abuser being a trusted, close, powerful person (for example family member, teacher, priest), dependency on abuser and inability to escape the situation (trapped, "hostage"), age of the victim (the young are likely to be affected more severely), and the duration of trauma (the longer the trauma, the poorer the prognosis) (Herman, 1992; Lemma, 2004; Lifton & Olson, 1999; McFarlane & van der Kolk, 1996; van der Kolk, 1996).

In complex trauma cases there are frequently few ameliorating but a large number of exacerbating factors. Trauma is mostly if not always human-caused, by a close person, who should be protecting rather than abusing, and the child is materially and emotionally

dependent on this person and therefore unable to escape, that is “those who are already disempowered or disconnected from others are most at risk” (Herman, 1992, p.60). This configuration additionally *prevents* the development of ameliorating factors, some of which depend on stable and benign role models, social support and the development of inner strength and a feeling of competence in the child. The secure attachment to a significant other, which safeguards an individual against trauma, cannot develop, and this complicates any subsequent relatedness including the therapeutic relationship (van der Kolk, 1996).

The ‘threat from within’ leads to confusion and ambivalence, since the person who would ordinarily be approached for safety and protection has become a source of danger (Herman, 1992, p.63). This leads to relationship breakdown, attachment problems, and disruption of the ability to regulate intimacy and aggression (Terr, 1999; van der Kolk, 1996), exacerbated by increased mistrust, onset of self-doubt and questioning of one’s judgment and perceptions regarding self, others and the world at large. These dysregulations, which tend to become entrenched behavioural patterns (Wilson et al., 2001), develop concurrent to and are maintained by neurobiological alterations (van der Kolk, 1996, 2006), which may present as diagnosable personality disorders in adulthood (Herman, 1992, 1999; Terr, 1999). This occurs without the person being aware of it. Defenses can become problematic later on when they are not useful or appropriate anymore, but have become automatic. The client’s presenting problem may then be related to difficulties with inappropriate defenses rather than original trauma, and symptoms may bear little or no resemblance to the DSM-IV-TR diagnosis of PTSD but rather to an Axis II diagnosis (Masterson, 1988).

Therefore complex trauma survivors constitute a very heterogeneous population (Taylor, 1998) and are often difficult to diagnose, especially when they are adult survivors of childhood trauma (Herman, 1992; Wilson et al., 2001). They are difficult to treat due to entrenched patterns and personality structures, and rigid defenses resulting from unique responses to traumatic events and environments (Lindy, 1996). Complicating features of complex trauma are loss of trust, inability to manage affect, and pronounced difficulties in relating interpersonally – all abilities needed for a therapeutic alliance to be established and to initiate healing (van der Kolk, 1996, 1999).

According to Taylor (1998) one third of trauma survivors fail to recover. Refractory cases and lifelong battles with trauma effects are not uncommon (Wilson & Lindy 2001), especially when trauma was layered, which is a frequent occurrence in chronic trauma presentations (Garland, 1998; Wilson et al. 2001). This may indicate a need for heightened caution in therapy to avoid further layering or re-traumatization, for example by dismantling defenses prematurely, or reacting punitively to violent acting out episodes of a client who may not be able to verbalize his / her distress and instead re-enacts the trauma (Knight, 2005; Wilson & Lindy, 1994).

2.2 Theoretical Positioning of the Study

This outline and brief exploration of theoretical frameworks serves as background and informs the subsequent detailed discussion of the case. To this end the core tenets of the psychodynamic approach to trauma, in particular complex trauma, including selected salient aspects of self-psychology and intersubjectivity relevant to trauma treatment are introduced and outlined. The contributions of the person – centered humanistic approach, aspects of which are also found in both self-psychology and intersubjectivity are pointed out. It is argued that these approaches are compatible and complement each other when conceptualizing and treating complex trauma. The integration of humanistic-existential and psychodynamic thought, especially taking the *I - thou relationship* into account, was introduced to therapeutic practice by Yalom (1980), who argued that the therapeutic *encounter* and the phenomenological understanding of the client's inner world is a most salient aspect of successful therapy.

2.2.1 Psychodynamic Approach to Trauma

The basic tenet of psychodynamic theory is the "acknowledgement of unconscious, repressed material as determining human behaviour" (Meyer, Moore & Viljoen, 1997, p.50). This implies that there are tensions between the conscious and various layers of the unconscious, which influence human behaviour. The nature of the repressed material and the origin and nature of the tensions are not easily accessible to the individual and are often expressed via various defenses and (mal-)adaptive coping mechanisms.

Freud conceptualized trauma as a frightful event piercing the protective mental shield of the individual, upsetting the person's mental equilibrium via intrusion of excessively intense stimuli (in Garland, 1998). Such an event then activates defenses ranging from archaic or primitive (for example splitting, projective identification, dissociation denial, paranoid thinking) to advanced (sublimation, humor, creativity) (Masterson, 1988; Sadock & Sadock, 2003). Defenses aim to ward off or filter the intrusive traumatic stimuli until they can be accommodated and integrated. If, however, the intensity and impact of the traumatic event is too strong and too prolonged, defense mechanisms get overwhelmed and cease to protect. The individual is flooded with the intense emotional stimuli associated with the trauma. The external violation is then experienced as an internal violation and raises primitive fears, activates feelings of intense anxiety, vulnerability, and a breakdown in mental structures related to trust, safety, predictability and goodness of the world (Garland, 1998; Herman, 1992).

The unbearable and unmanageable affective reactions caused by trauma, may also lead to lasting alterations in perception and state of consciousness in an attempt to protect the individual's psyche via blocking of unmanageable emotions. These alterations have been described as "dissociation" by Janet and as "double consciousness" by Breuer and Freud (in Herman, 1992). They form part of the symptom cluster found in patients suffering from long term complex trauma (Putnam, 1999; Wilson et al. 2001).

Such damage to internal, mental structure, may lead to arrest, delay, stagnation or regression in personality development (Masterson, 1988). The individual might not be able to achieve the goals of the relevant developmental phases and continue to struggle with issues related to trust, autonomy, initiative and identity (Erikson, 1968). The individual may 'get stuck' in the developmental phase during which the trauma occurred, or regress to an earlier developmental phase, particularly if prior trauma has been activated. Garland (1998) argues that it is particularly this connection between present and past that makes trauma so hard to undo, because perception or interpretation of current events tends to be influenced by the memory of past traumatic events, similarly to a self-fulfilling prophecy. In severe cases, particularly if trauma occurred during the formative years and was of a long-term nature, ego and personality development may be so distorted that personality malformation results (Herman, 1992; van der Kolk, 1996; Wilson et al. 2001). The ego or self does not develop coherence and integration but

becomes split and fragmented in an attempt to at least partly escape annihilation by unmanageable trauma. The long term after effects are symptomatic of borderline personality disorder, dissociative disorders, and multiple personality disorder (Herman, 1992, 1999; Lewis & Volkmar, 2000; Putnam, 1999).

The damage done by trauma is “neither trivial nor temporary” (Garland 1998, p.11). A fragmented self has lost, or failed to develop, the ability to recognize, verbalize, regulate and manage emotions, realistically assess potential threat, or contemplate events / stimuli before acting upon them. These deficits affect an individual’s perception of self, others, the world and his / her ability to initiate, respond to and maintain relationships. Particular difficulties are experienced in the area of intimacy (Herman, 1992), which requires an autonomous person with appropriate levels of trust, frustration tolerance and an appropriate perception of reality.

Survivors of trauma frequently appear to seek out trauma-similar situations or re-enact the traumatic event in subsequent situations and interactions, such as the therapeutic relationship, in an attempt to gain mastery over the trauma. This repetition compulsion may at times be the survivor’s only means to communicate his / her distress due to an inability to conceptualize or verbalize the psychic damage and accompanying intense and painful affect (Garland, 1998; Wilson & Lindy 1994). This highlights the importance of the awareness of trauma-specific transference and counter-transference processes in the therapeutic relationship as well as the intense emotional impact thereof on the therapist (Herman, 1992; Klain & Paviae, 1999; Wilson & Lindy, 1994; Wilson et al., 2001).

2.2.2 Self-psychology

Self-psychology can be described as an expansion of psychoanalytic depth psychology. Kohut is the main proponent of this approach and is said to have “revolutionized psychoanalysis by making it more humanistic” (Kahn & Rachman, 2000), struggling with and finally incorporating many of the issues Rogers raised decades earlier, such as the focus on empathy in the healing process of therapy, the importance of relatedness of the self, the holistic focus, views on a person’s potential for growth, as well as the relative importance of emotion versus cognition in therapy (Tobin, 1991). These important

components complement aspects essential to psycho-dynamic (but not humanistic) psychology, such as transference / countertransference, the importance of the past in therapy, developmental aspects, and the recognition of the importance of the unconscious. The more humanistic aspects of self-psychology find expression not only in conceptualization but even more so in clinical application, that is treatment. Some of them are taken further by the later movement towards intersubjectivity, which takes interpersonal relatedness somewhat further.

Terminology differs between humanistic psychology and self-psychology, and though this study focuses on conceptualization employing self-psychology (and therefore using its terminology), elaborations on therapeutic *procedure* include terminology from person-centered psychology, which influenced Kohut's self-psychology strongly, and which has been integral to the treatment of this case.

Self-psychology essentially focuses on "reactivation of thwarted developmental needs in the transference via the discovery of the self-object transference" (Kohut, 1984, p.104). Kohut developed his theory while working with patients who suffered from narcissistic personality disorder, which he viewed to be rooted in "a weakened or defective self" (Kohut & Wolf, 1978, p. 414) similar to the *false self* described by Rogers (1980). This weakness or defect may be caused by trauma to the developing self during the formative years, particularly if the trauma was caused by the primary care giver.

He introduced the concept of "self-objects" as objects which are experienced as parts of the individual's self and which one expects to have control over, similar to an adult's control over his body (Kohut & Wolf, 1978). He distinguishes between the mirroring self-object, which "respond[s] to and confirm[s] the child's innate sense of vigour, greatness and perfection" and the idealized parent imago "to whom the child can look up and with whom the child can merge as an image of calmness, infallibility and omnipotence" (Kohut & Wolf, 1978, p.414). This conceptualization is somewhat reminiscent of Roger's "unconditional positive regard" (Mearns & Thorne, 1988), which parents ought to provide for their children, for them to develop a positive self-concept. According to self-psychology, development of a coherent and firm self occurs if the child experiences optimal interaction with his self-objects, including optimal and bearable frustration of the child's mirroring needs. This process activates the two poles of basic strivings for power

and success and basic idealized goals, as well as an intermediate area of basic talents and skills between these ambitions and ideals (Kohut & Wolf, 1978).

If the child has experienced severe or prolonged faulty interaction between himself and his self-objects, for example if abuse, maltreatment or neglect occurred, particularly when committed by primary care givers, a damaged self is the result. The damage may be diffuse or may centre on one of the above mentioned parts of the self. Kohut and Wolf describe this damage as a "state of self disorder" (1978), characterized by fragmentation, a lack of cohesion, vigour and harmony. They point out that fragmentation, enfeeblement and break-up of the self are particularly prevalent in what is commonly diagnosed as borderline states / disorders, and adds that it is frequently covered by complex defenses. This coincides with Herman's (1992) description of the presentation of individuals with complex trauma syndrome, and also with the Rogerian conceptualization of loss of trust in one's real, organismic self, due to internalized conditions of worth placed upon the person by significant others (Mearns & Thorne, 1988), which compromises growth for the sake of security (Yalom, 1980).

Kohut and Wolf argue that it is not so much occasional or singular parental failure or distinct traumatic events that will result in a child's damaged self, but rather that those events are just pointers towards the true cause of damage, that is "the unwholesome atmosphere to which the child was exposed during the years when his self was established" (1978, p.417). If parents are not sufficiently sensitive to the child's needs but instead respond to their own needs due to their own insecurely established selves, the child is likely to suffer serious deficits in self-development. Similarly, Rogers (1980) conceptualizes this process as estrangement from self and one's experiencing organism, and resultant isolation and despair in conjunction with the inability to relate to others due to disconnection from the real self. This correlates with findings on the results of ongoing exposure to trauma in childhood (McFarlane & Girolamo, 1996; Nader, 2001; Terr, 1999, Turner et al., 1996).

The result of such damage is the persistent need and search for either mirroring or idealized transference to re-live and possibly repair the damaged structure. Therapy therefore needs to be focused on the rehabilitation of the self rather than on symptom relief via education or symptom suppression, which are important but secondary. In

therapy the unfulfilled and previously unresponded to needs of the individual are re-activated and a self-object transference is established with the therapist as self-object; or as Trop (1995) puts it: “patients will be motivated to mobilize and seek out self-object experiences to transform developmental deficits” (p.32), that is to constructively re-live growth experiences that were denied or unavailable in childhood. The client eventually internalizes functions and services of the self-object (therapist) via transmuting internalization (Kohut & Wolf, 1978), which can be likened to internalizing benign, positive, vital aspects of the other, making them part of one’s own psychological repertoire.

The focus on relatedness in the therapeutic process and on availability for the client who, however, has to find his own way to remove the blocks in his development and growth, corresponds with Rogers’ (1980) views on person-centered therapeutic intervention.

The aim of therapy is that of repairing damage to the self via uncovering, exploring and fulfilling of unfulfilled needs via mirror transference or idealizing transference. The goal is not to ‘get rid’ of childhood demands and needs but to mobilize and explore them in a benign, supportive environment. It is uncovering and understanding “without censure” (Kohut & Wolf, 1978) and with empathy (Mearns &Thorne, 1988; Okun, 1990; Rogers, 1980), rather than continued suppression and repression of unfulfilled needs, that will lead to a firming and re-vitalising of the client’s self and that will make a creative and fulfilling existence possible.

This process demands, and is in fact based on, exceptionally good rapport and attunement between therapist and client (Buirski & Haglund, 2001). The therapist needs to be able to show that he is “in tune with the patient’s disintegration anxiety and shame concerning his precariously established self” (Kohut & Wolf, 1978, p. 424). This emotional attunement affects the therapist as much as the client and the intensity of the process frequently results in strong counter-transference reactions, particularly when fragmentation of self and anxiety are intense, as tends to be the case in presentations survivors of childhood- or chronic / complex trauma (Herman, 1992; Lindy 1996, Wilson & Lindy 1994; Pearlman, 2001).

2.2.3 Intersubjectivity

Intersubjectivity is linked to Self-psychology in a number of ways. It can be argued that intersubjectivity is a natural continuation and expansion of self-psychology, as well as a relational process theory, contextualizing other psychological approaches (Stolorow, Orange & Atwood, 1997). In this context, psychological trauma is understood in terms of relational systems, which failed to assist the individual in tolerating, containing, modulating and integrating painful affect associated with potentially traumatic events (Stolorow, 1999). Estrangement and isolation, that is disconnection from others and even from oneself are highlighted as inherent aspects of psychological trauma (Stolorow, 1999).

According to Trop (1995) the following similarities and differences are most salient with regards to self-psychology and intersubjectivity: both are relational theories and though they form part of the depth-psychological and psycho-dynamic continuum, they both reject the concept of drive as primary motivational source. Both also use a stance of empathy and introspection as a central guiding principle in therapy, and have been influenced in their development by humanistic psychology.

However, in contrast to self-psychology, intersubjectivity does not focus on the concept of the self-object but on “a more broad-based striving to organize and order experience” (Trop, 1995, p.32). The motivational principle of intersubjectivity is the “need to maintain the organization of experience [a]s a central motive in the patterning of human action”, implying that each person establishes “unique organizing principles that automatically and unconsciously shape his or her experience” (Trop, 1995, p.32).

“In the absence of reflection, a person is unaware of his role as a constitutive subject in elaborating his personal reality. The world in which he lives and moves presents itself though it were something independently and objectively real. The patterning and thematizing of events that uniquely characterize his personal reality are thus seen as if they were properties of these events rather than products of his own subjective interpretations and constructions” (Atwood & Stolorow, 1984, p.36). This unawareness of one’s organizing principles, for example one’s defenses post trauma, implies that once established, activated, and operating, they are difficult to change or even recognize

because they are insidious, automatic and ever-present. Their de-contextualization insulates defenses and other patterns from dialogue to prevent them from being challenged or invalidated (Stolorow, 1999). They become absolutes and are hard to change, which is illustrated, for example, by the entrenched personality malformations understood to be part of complex trauma.

It can therefore be argued that intersubjectivity, which involves interacting individuals and their context, is central to our experience of the world, and that it is ever-present in a therapeutic context too. In the therapeutic context, however, neutrality and objectivity on part of the therapist are highly treasured characteristics which are viewed as essential in most psychological approaches. Intersubjectivity, however, raises the question if neutrality and objectivity are indeed possible or even necessary or desirable in therapy (Benjamin, 1990).

Intersubjectivity in fact precludes neutrality, since the term refers to the field of meeting or overlap of two subjectivities (for example client and therapist), and their co-creation of their reality. This may include the client's engagement with the therapist as a self-object as one of the organizing principles to create meaning in the world as he sees it. Since 'self' is not a static concept, both the therapist's and the client's self and their interaction is subject to a continuous re-creation and re-negotiation of the therapeutic relationship, that is the possibility of subtle and not so subtle, unconscious (especially on part of the client), or more explicit and intentional shifts and changes in the subject's organizing principles, including the perception of self and its place in context. Buirski and Haglund (2001), Goldberg (1988), and Stolorow and Atwood (1997) all advocate for authenticity and realness as a person in the therapist, rather than a neutral or blank canvas. This emphasis on genuine relatedness and investment of the therapist's self throughout the healing process and not merely to establish initial rapport is congruent with Roger's (1980) notion of successful therapy.

The acceptance of the other as a subject is essential for the self to experience his or her subjectivity fully in the other's presence (Benjamin, 1990). This requires a high degree of awareness and emotional engagement from the therapist, since "being present gives presence to the other" (McDermott, 1986 in Mearns & Thorne, 1988) by confirming his importance, worth and mere presence, via both witnessing and acceptance. This implies

that a constant re-negotiation and shifting of power needs to be recognized as taking place in therapy. The notion of the powerful, 'knowing' therapist and the disempowered, 'ignorant' client needs to be replaced by that of two individuals co-creating a journey. This is of particular importance for chronically disempowered long-term trauma survivors who often perceive the world and relationships as unpredictable, uncontrollable and unmanageable (Herman, 1992) and need to experience individually paced re-empowerment in a safe and trusting environment.

Intersubjectivity does not imply that each individual simply attempts to understand the other's world, but rather that each becomes increasingly aware of and accepts his own 'baggage' of ideas, emotions and preconceptions that he brings into the interaction, how these influence the interaction, and how both individuals are involved in co-creating reality. This is not limited to the two individuals and therapeutic encounter only, but includes taking into account how broader contextual issues (for example societal issues) impact on each person's subjectivity and therefore the process.

2.3 Compatibility of Theoretical Frameworks and Applicability to Trauma

The theoretical approaches outlined above are part of the spectrum of depth psychology, though they have different areas of focus and vary on a continuum from primarily supportive to primarily explorative.

Psychodynamic approaches, in particular self-psychology, contend that psychological trauma causes fragmentation of intrapsychic constructs, such as the self and how it is experienced and expressed by the individual with regards to himself as well as in relationships. Intersubjectivity focuses on how interpersonal interaction, that is context, contributes to both traumatization and healing. This is of particular significance if the trauma is human caused and has occurred within the context of early and intimate relationships.

Both theoretical approaches focus on repair or rehabilitation of the structure of self with assistance of and in interaction with others, primarily the therapist. While self-psychology is primarily concerned with re-building of a coherent and vital self, intersubjectivity focuses on re-establishment of active interconnectedness with others

and rehabilitation of the ability to meaningfully relate to others. Both approaches consider relationships with others as formative in both trauma etiology and treatment as well as healthy functioning. The focus on healthy interdependence of well-functioning (individuated) individuals, rather than mere individual autonomy constitutes an expansion of Rogers' concept of what constitutes mental health.

2.4 Treatment Approaches for Complex Trauma

Due to a wide variety of conceptualizations of trauma, difficulty diagnosing it, as well as its diversity of symptoms and presentation, various treatments have been developed and are practiced today. This section serves to explore why many treatment options which successfully assist survivors of once-off or short-term trauma are not as successful in healing survivors of complex long-term trauma. It is proposed that for these complex and refractory cases, a holistic, client-paced, client-centered, and individualized psychodynamically based approach with a strong therapeutic relationship may be most beneficial.

Subsequently, Herman's treatment approach will be mapped out as an illustration of psychodynamic, phased, trauma treatment with focus on the therapeutic relationship, which aims to fill some of the above-mentioned gaps, and critically discuss its application.

2.4.1 Trauma Treatments and Their limitations

Historically, treatment for trauma survivors consisted of attention to physical injury, attempted symptom relief with regards to somatic and neurological complaints, and possibly hospitalization in an asylum, if symptoms were of a disturbing behavioural nature. Before Freud postulated psychological trauma as causative to somatic and neurological complaints, trauma was conceptualized either as an individual weakness or character flaw or a physical rather than mental illness, and treated as such.

In 1980 psychological trauma was conceptualized as a diagnosable mental health condition in the Diagnostic and Statistical Manual of Mental Disorders-III (1980), partial de-stigmatization took place, and symptomatic treatments were explored. These were

based on the symptoms that were most visible and were experienced as most disabling by patients (or their superiors, for example in a combat situation), such as anxiety, somatic complaints including conversion symptoms, avoidance symptoms and intrusive memories. As a result, medical, pharmaceutical, and cognitive-behavioural treatments (CBT) were developed (Zoellner et al., 2001), focusing on alleviating anxiety, flashbacks, avoidance reaction, and somatic symptoms, with the aim to re-integrate Vietnam War veterans back into 'normal' society as soon as possible. Many of these treatment approaches show great success in alleviating symptoms and suffering of specific homogeneous groups of trauma survivors, but positive outcomes are less pronounced with regards to multiply and chronically traumatized individuals (Foa & Cahill, 2002; Dept. of Veterans Affairs, 2006).

Freud's "talking cure" as a treatment for trauma receded into the background until it was 'rediscovered' a few decades ago. Herman (1992) argues that this shift (or full circle) is based on the initial trauma condition, "hysteria", having been conceived of and applied to females only, then having fallen into disuse while trauma was conceptualized in terms of (male) war trauma, and the concept as well as the psychodynamic (or psychoanalytic) treatment of what is now essentially seen as complex trauma only came into focus again during the feminist movement in the later part of the 20th century when the abuse of women and children was more widely acknowledged and researched. Until that time, the focus remained mainly but not exclusively on cognitive-behavioural treatments as remedy for discrete traumatic events (Herman, 1992).

Cognitive behavioural and exposure-based treatments are well researched and prove highly successful in alleviating anxiety, hyperarousal and intrusive memory symptoms in trauma survivors (Zoellner et al., 2001; Wilson et al. 2001, Dept. of Veterans Affairs, 2006). Adjunctive treatments, such as Image Rehearsal Therapy to treat recurring nightmares, stress inoculation therapy to achieve relaxation, psycho-education, pharmacological interventions, and hypnotherapy proved to be useful and effective treatments for a variety of symptoms as well as co-morbidities, for example depression, tension, and aggression (Dept of Veterans Affairs, 2006). These treatment options, however, are not aimed at healing damage to the client's self or his interactional ability, which are intrinsic symptoms of complex trauma, though there seems to be an implication that these will improve once the presenting symptoms are under control.

Furthermore, exposure-based cognitive behavioural treatments “may not be appropriate for use with clients whose primary symptoms include guilt, anger, or shame” (Foa, Riggs, Massie & Yarczower, 1995), actively suicidal or homicidal clients, and substance abuse which is not in stable remission (Foa, Rothbaum, Riggs & Murdock, 1999; Dept. of Veterans Affairs, 2006), all of which are components of the symptom cluster of complex trauma (Herman, 1992; Pearlman, 2001).

Cognitive exposure therapies require the client to recall the traumatic event and to create a motivated and intentional mind-shift to positive replacement images and cognitions. Remembering the traumatic event(s) may not be possible for some clients, either because they cannot access them (for example when trauma occurred or commenced during infancy / early childhood), due to long-term repression of images which has resulted in blurring, due to there being too many images from ongoing chronic abuse, or due to the images being too complex, too severe, or affective and physiological rather than visual (van der Kolk, 2002). Ongoing emotional and psychological abuse in childhood may not be perceived as traumatic by a client who grew up in an environment where such conditions were endemic. Treatment might more likely be requested for co-morbid symptoms (for example anger management problems, depression, alcohol abuse, et cetera) which were not immediately associated with trauma etiology but should have been identified as components of the complex trauma syndrome.

Additionally, consciously induced imaging of traumatic events, even in the relatively safe therapeutic situation, may lead to re-traumatization of chronically traumatized, unstable and rigidly defensive clients (Lindy, 1996; Wilson & Lindy, 1994), which creates higher drop out rates than in other treatments (Foa et al., 1999; Dept. of Veterans Affairs, 2006). Exploration of traumatic memories needs to proceed at the client’s pace, and requires patient, sustained relationship building, so as to first establish a climate of safety and trust, to avoid re-traumatization. This might be difficult if not impossible to achieve in the limited number of sessions usually allocated to exposure-based treatments.

Creating positive counter-images may also pose a problem for the client who feels he / she possesses only negative cognitions and has only few positive ones, or none at all, or cannot 'believe' in positive images, as is the case when trauma has deformed the individual's self and modified personality, and a self-perception of being essentially 'bad' has taken hold (Herman, 1992).

Eye Movement Desensitization and Reprocessing (EMDR) is a helpful treatment component, especially when co-morbid depressive and anxiety disorders are present (Turner, McFarlane & van der Kolk, 1996, 2007) but contraindicated if the client has a history of dissociative disorders (Dept. of Veterans Affairs, 2006), which are, however, an integral component of most complex trauma presentations (Herman, 1992; Putnam, 1999; Spiegel et al., 1999). According to Turner et al. (1999) EMDR is generally not very effective with chronic trauma populations, which are also often resistant to pharmacological and cognitive-behavioural interventions. Zoellner et al. (2001) advocate caution regarding the results of successful EMDR trials, citing methodological flaws which make the effects 'inconclusive'.

CBT approaches appear to focus more on technical aspects of treatment, using manuals and structured pre-determined formats of treatment, rather than primarily focusing on the relationship between therapist and client. This may be due to the briefness of the interventions (generally 6-8 sessions) compared to psychodynamic approaches, as well as the perception that 'rapport' can be established in the first session/s as a base for commencing with a treatment technique. The therapist remains in a neutral or objective and benign stance. This modus operandi may be ineffective when working with survivors of complex trauma who as a rule exhibit significant impairment of trust and great difficulty establishing interpersonal relationships (Herman, 1992; Pearlman, 2001; van der Kolk, 1996; Wilson et al., 2001).

2.4.2 Treating Complex Trauma Holistically

Due to the difficulties inherent in diagnosing complex trauma in its manifold presentations, and the above described limitations of exposure based therapies which seem to aim more at well-diagnosed DSM IV type PTSD, other treatment modalities may be more suited for the complex trauma client. Due to the lack of trust and impaired

ability to interact interpersonally, much attention to the therapeutic relationship is crucial to initiate therapy, to retain the client in therapy (Lindy, 1996) and to avoid re-traumatization. Therefore, a relationship-focused, psycho-dynamically conceptualized treatment approach, using a range of client-centered methods, may be indicated because "[r]ecovery can take place only within the context of relationships; it cannot occur in isolation. In her renewed connections with other people, the survivor re-creates the psychological faculties that were damaged or deformed by the traumatic experience. These faculties include the basic capacities for trust, autonomy, initiative, competence, identity and intimacy" (Herman, 1992, p.133). The Department of Veterans Affairs' Clinical Treatment Guidelines (2006) recommend psychodynamic psychotherapy as first line treatment for survivors suffering complex trauma, particularly if the trauma consisted of childhood sexual abuse, and recommends adding adjunctive therapeutic interventions when appropriate. Perlman (1996), van der Kolk (1996) and Wilson et al. (2001) support the use of adjunctive interventions in addition to psychodynamically based therapy.

Psychodynamic psychotherapy may initially be purely supportive (Holmes, 1995; Werman, 1989), utilizing strategies characteristic of person-centered approaches, such as reflections, unconditional positive regard, congruence, and empathy (Grobler et al., 2003; Mears & Thorne, 1988), which may be psychodynamically conceptualized as affective attunement or attuned responsiveness (Buirski & Haglund, 2001) with the aim to enable an authentic corrective emotional experience (Knight, 2005). The combination of using person-centred therapeutic strategies in therapy while conceptualizing the case psychodynamically is not contradictory but complementary, since both approaches share the aim of healing the client by allowing him to grow towards true selfhood, rather than aiming at mere behavioural adaptation (Kruger, 1986).

Gentle exploration and interpretation are introduced gradually as soon as the client can manage more intense affect (Herman, 1992; Holmes, 1995; Werman, 1989). The client will often indicate his readiness by self-initiating deeper exploration of specific concerns. The focus is on the *gentle* uncovering and managing of images, fears, and defenses related to the trauma, which block access to the unspeakable and unthinkable, which is depriving the person of vitality (Dept. of Veterans Affairs, 2006; Okun, 1990). Emphasis is placed on holistic and empowering treatment of the client within a trusting and caring therapeutic relationship, rather than merely a reduction of initial presenting symptoms

(Mearns & Thorne, 1988; Wilson et al., 2001). Current issues as well as traumatic past is addressed and connections between past events and current behaviour are explored, to make "sense of the apparently meaningless" (Garland, 1998, p.28) and to assist and accompany the client on his / her journey back into life. The therapeutic aim is to move from re-enacting the trauma to mentalizing (putting into thoughts) and verbalizing (putting into words) unmanageable emotions / events in a safe environment, and so to acquire the ability to mourn losses similar to bereavement (Levy & Lemma, 2004), to assimilate the trauma via integration of affect (Young, 1998), and to re-discover or develop a self that is vital and creative and experienced as *benign*, *good* and *capable*. Jacob (1998) adds that *naming* of feelings rather than labeling is restorative, and that the therapist's witnessing of the client's progress rather than specific activities by the therapist allow for gradual healing. This resonates with Roger's (1980) stipulation that "[w]e are deeply helpful only when we relate as persons, when we risk ourselves as persons in the relationship, when we experience the other as a person in his own right" (p. 179). Knight (2005) concurs and cautions of over-activity on the side of the therapist. This call for seeming inactivity is echoed by Bion (1980, in Casement 1991): "Discard your memory; discard the future tense of your desire; forget them both, both what you knew and what you want, to leave space for a new idea", which in the therapeutic situation may translate into providing the setting but leaving pace, direction and content largely to the discretion of the client – a true person-centered therapeutic setting with underlying psycho-dynamic conceptualization and understanding of the case.

This creates a situation where the therapist needs to be able to tolerate 'not knowing' and 'not doing', but rather learning from the client (Casement, 1991; Jacob, 1998). Particularly as a junior therapist, however, one may feel that one needs to apply certain techniques to see some *progress* and *improvement* in the client's functioning so as to justify the therapeutic intervention and to reduce anxious doubts if one is in fact *doing a good job*. The slowness and seeming passivity of the relationship-focus psychotherapy, including availability, consistency and continuity, may feel counter-intuitive to the socially prevalent push for brief treatments, the efficacy of which is measured by short term reduction of symptoms. Speeding up the process due to time constraints or therapist anxiety might, however, lead to secondary traumatization of the client.

Summarily stated, a relationship with a non-retaliating and containing person, the therapist, is essential, because the enabling of trust as well as the practice of relating to another person, rather than merely gaining intellectual insight, is the focus of the interaction.

Availability, predictability, regularity, and boundaries are primary components of the therapeutic relationship that support the client by providing structure (Herman, 1992; Holmes, 1995), while containment and validation promote safety and facilitate gradual opening up (Garland, 1998; Levy, 2004). The healing process may take months or years, including the ongoing maintenance of and re-establishment of relative safety as perceived by the client, due to the gravity and depth of damage caused by chronic trauma. Initial dependence on the therapist is common and expected, and represents a healthy step on the way to increasing empowerment, separation, individuation and autonomy once a more vital and coherent self has developed (Goldberg, 1988; Kohut & Wolf, 1978). This process represents the re-living (or in some individuals, in fact, the first experience of) the mastering of the psychological developmental stages (as detailed by Erikson, 1968), which were disrupted by the trauma experiences. A successful interpersonal relationship on an equal basis is less likely to feel threatening or over-powering to the client only once the client has achieved a certain degree of autonomy, vitality and individuation.

For such a long-term process to be successful, therapy needs to be individualized and client-paced, to avoid re-traumatization and affective overload. To allow the client to set the pace, yet to contain him / her at the same time, that is to sit with an at times extremely 'slow' process, may tax the therapist's ability to remain in the immediacy of the moment (Grobler, Schenck & du Toit, 2003) and to manage his own feelings in response to the client and the situation.

Therefore, awareness and utilization of transference and countertransference inherent in the therapeutic relationship are important aspects of the therapeutic relationship and process. The concepts are here used more broadly than the original Freudian conceptualizations. In this paper, transference refers to the client's reactions to and interpretations of the therapists activities or qualities, as well as his projections onto the therapist based on the client's prior experiences as well as the present (Buirski &

Haglund, 2001). Countertransference refers, in line with the victimization literature, to the "feelings, images and thoughts that accompany work with trauma survivors" (McCann & Pearlman, 1999, p. 501), which include the client's unique responses to client material as shaped by both characteristics of the situation and the therapist's unique psychological needs and cognitive schemas" (McCann & Pearlmann, 1999, p.502).

Mostly, the therapist would not explicitly interpret or make the client aware of transference, particularly during the initial stages of treatment, because the self is not yet firm enough to assimilate such interpretations. A high level of awareness and self-monitoring (Holmes, 1995; Wilson & Lindy, 1994) is required from the therapist, so as to identify and therapeutically understand the client's often intense and seemingly inappropriate affect, as well as specific trauma re-enactments. Simultaneously, the therapist needs to monitor his own emotional responses, which are significantly more pronounced and intense when working with trauma survivors (Garland, 1998; Herman, 1992; Klain & Paviae, 1999; Lindy, 1996; Wilson & Lindy, 1994; Wilson et al., 2001). The therapist must be able to bear much hatred, anger, expectations, and demands, which are projected at him in the trauma re-enactment transference and should be aware of and manage feelings of revenge, wanting to avoid / desert, wanting to overprotect, or lash out, which are common manifestations of countertransference (Wilson & Lindy, 1994) and which must be borne rather than avoided (Knight, 2005)

Often there is only little improvement in the short term with long term, chronic trauma clients, which may create the impression that there is no or little improvement when this modality is used, rather than the improvement taking more time. It is important that therapeutic goals be realistic because in some cases, trauma reactions have developed into a chronic and severely debilitating psychiatric disorder that is refractory to current available treatments. Harm is done and hope is violated and manipulated if quick or unrealistic outcomes are promised and then don't materialize (Lemma, 2004; Wilson et al., 2001), or if only co-morbidities and active symptoms are treated. Therefore, there is a need for "a comprehensive, individualized, evidence-based, theory-guided approach […] to treat the sequelae of complex trauma" (van der Hart, Steele & Ford, 2000, p.10)

4.2.3 Self-psychology and Intersubjectivity Applied to Therapeutic Interventions

Self-psychology advocates reflection rather than interpretation (Holmes, 1995), which is an essential component of the establishment of safety and trust, the highly important initial phase in the treatment of trauma survivors (see also 4.2.4). Since self-psychology conceptualizes damage to the self via trauma as a failing of primary care givers, that is significant others, in the individuals formative years, it consequently considers the therapist's way of being rather than behaviour management or education techniques to be of primary importance in the therapeutic situation, enabling both the contained re-enactment of the traumatic situation and providing the save environment for successful completion of previously non-achieved milestones, such as trust, autonomy, initiative, industry and identity (Erikson, 1968) via mirroring and idealizing in an empathic relationship (Kohut & Wolf, 1978). The achievement of these milestones leads to a more vigorous and 'alive' self with increasing ability to access creativity. This indicates that self-psychology may be a useful approach particularly during the initial holding stage of therapy, when clients are fragile and their self is fragmented, and supportive rather than explorative therapy is needed to provide both space and containment for the client. This implies that the therapist is often *perceived* by the client in more 'expert' or powerful stance initially, to enable to client to feel safely held in a calm therapeutic space, by a non-retaliating therapist, whom he can idealize. Consolidation of safety will take time, and the calmness and patience of the therapist will be tested repeatedly via a number of trauma related projections and transferences from the client (Masterson, 1988) who might need to relive his traumatic experience with a 'bad object', which this time can bear the attack without retaliating or disintegrating (Knight, 2005). Therapeutic progress is possible only if this difficult phase is not avoided but rather helplessness is survived by the therapist without falling into rescue mode but continuing to be present with empathy, also conceptualized as unconditional positive regard (Mearns & Thorne, 1988, Rogers, 1980). The therapist can only become an object of hope if he can bear the pain of not rescuing and so illustrate that helplessness can be survived (Lemma, 2004). If safety can thus be established and a relatively secure attachment exists between client and therapist, it becomes possible to venture forth and explore the trauma and its effects. This does not imply that the process is linear and uncomplicated. The establishment of relative safety and trust, the cornerstones for a sustainable therapeutic alliance, may take months or years (Maroda,1990, in Wilson & Lindy, 1994). The client in fact might

"often appear *to get worse* before getting better" (Mearns & Thorne, 1988), mainly due to renewed engagement with life in all its (often painful) facets, the subsequent experiencing of new and previously repressed intense feelings such as aggression, anger, sadness or loss, which the client had thus far avoided and has no blueprint for managing.

Therefore, within the self-psychological framework, the relationship which client and therapist create is less 'equal' compared to the intersubjective view where both client and therapist are assumed to co-create therapeutic space in a more equally participative way. The staged or phased use of these two approaches parallels the client's journey from fragmented self and an inability to relate, to firstly a more stable and coherent self and subsequently increased ability to voluntarily, actively and less anxiously relate to others.

Intersubjectivity as a meta-theory or approach rather than a method is open for inclusion of valuable techniques and methods from other approaches since it is centered on relationship and inter-relatedness, that is context. Since interpersonal trauma is conceptualized as damage to the ability to relate interpersonally and consequently, treatment focuses on re-establishment of human interrelatedness via a multitude of methods, depending on the needs of the particular client. Empowerment of the client via identifying, naming and integrating affect and traumatic memories, joint decision-making and exploration of patterns that have been damaged or turned dysfunctional as a result of trauma, are the primary aspects of treatment. This is particularly important in the middle and later phases of treatment when uncovering of trauma and its relatedness to the present are explored, and is possible only once the client feels reasonably safe and has established a more coherent and less fragmented self.

Empathic attunement is considered essential and highly significant in both approaches but to different degrees (Buirski & Haglund, 2001; Trop, 1995). Self-psychology focuses on staying empathically attuned with the client and to avoid or reduce miss-attunements. Intersubjectivity advocates using miss-attunements as opportunities to uncover and explore and shift patterns and organizing principles, such as defenses, that are dysfunctional and (no longer) helpful. It appears that stable attunement, with only few and minor breaks in attunement, is most important in the early phases of treatment when

the client is as yet unable to tolerate ambivalence, and may have very rigid trauma-related schemas / defenses. Miss-attunements are accepted and worked through more easily as challenges and possibilities for growth, rather than therapeutic failures, at later stages of treatment once the client has gained some self – acceptance, and the ability to tolerate some frustration, ambivalence, and more intense affect.

Transference and countertransference take place in the intersubjective space of the therapeutic relationship and can be seen as yet another "unconscious organizing activity" (Trop, 1995, p.33) which the client brings to the process attempting to create meaning, and to which the therapist responds. The transference and counter-transference process is termed co-transference in intersubjective theory (Buirski & Haglund, 2001) denoting the active participation of both client and therapist in this process of creating meaning in the intersubjective space. Roger's (1957) understanding of the I – Thou relationship in the here and now of the therapeutic encounter may be understood as yet another way of conceptualizing this interaction.

In the initial stage of therapy self-object transferences are common, which "represent one of a multiplicity of unconscious, automatic, and repetitive ways that patients organize their experience of the analyst" (Trop, 1995, p.33) as a symbolic stand-in for either perpetrator, bystander, supporter or a mixture of these representations in the client's internal frame of reference. With increasing stabilization of the client, interpretation and exploration of these often non-verbal re-enactments become more frequent and more successful, leading to healing instead of re-traumatization, and with increasing awareness of re-enactment and transference processes, often understood more readily as *organizing principles*, the client's awareness about his response patterns to internal and external events, their origins and consequences, increases, which may help to understand and integrate trauma in his / her life history and systems of meaning. Finally, client and therapist explore ways to modify these patterns to enable conscious rather than automatic (trauma-related), and vital rather than defensive or numbing responses to stimuli.

2.4.4 Phase-oriented Treatment

A general consensus exists, that phase-oriented treatment is the standard of care for complex trauma (Brown et al., 1998, in van der Hart et al., 2000; Wilson et al., 2001). A variety of phased treatment approaches exist, and can be found across a wide variety of approaches (Lindy, Wilson & Friedman, 2001). Stages generally comprise the establishment of a therapeutic relationship based on safety and trust, recovery and verbalization of traumatic memories and mourning, and integration of meaning, including reconnection with self and others. The aim is to establish trust and a stable therapeutic relationship before delving into traumatic memory, the exploration and resolution of which assists the client to assimilate the trauma and associated affect and to re-focus on the present and future. Psychodynamic, phase-oriented approaches are open to be tailored to individual cases with regards to speed, timing, and addressing relevant co-morbidities as well as current issues and relationship problems.

2.4.5 Herman's Three Phase Treatment Approach

This phased approach consists of three stages, namely: Safety, Remembrance and Mourning, and Reconnection. Additionally, Herman (1992) emphasizes that recovery cannot take place without a healing relationship occurring in therapy. A brief outline is provided regarding the dynamics usually occurring in each stage.

<u>Stage 1: Safety</u>

During this initial stage the focus is on the establishment of the therapeutic relationship on a foundation of trust and safety. This requires regularity, setting of boundaries, and a consistent holding environment. Trust in another as well as trust in oneself has to be slowly reestablished (Lemma, 2004). Attention is given to Axis I, II and III conditions simultaneously, as it is an integrated approach. The implication is not that all concerns (which may be conceptualized as co-morbidities) are addressed in each session but rather that they are understood to form part of the trauma syndrome and need to be explored in conjunction with the initial trauma and resultant defenses. During this phase attempts at elimination or management of dangerous behaviours and relationships, self-harm, substance abuse, impulse de-regulation, and external as well as internal

aggression are paramount (van der Hart et al., 2000). Establishment of external safety is absolutely essential prior to any exploratory work (Gibb, 1998; Turner, McFarlane & van der Kolk, 1996). Safety issues will continue to re-emerge throughout the entire therapeutic process (Lindy & Wilson, 2001) but are likely to be better managed at later stages, once some therapeutic gains have been made.

Stage 2: Remembrance and Mourning

This stage focuses on the processing and resolution of traumatic memories via thickening narrative accounts of the trauma experience, which proceed in a slow client-paced manner. Affective states connected to traumatic experiences need to be accessed, felt, verbalized and explored simultaneously with event / incident recollection. Tentative connections between emotive here-and-now events and trauma-related affect can be made, the timing of which needs to be adjusted to the client's level of integration or fragmentation. The careful timing requires some intuition from the therapist with regards to when to assist in uncovering and when to assist with encapsulating traumatic memory (Lindy, 1996). The aim is to avoid re-traumatization and dissociation. Mourning of intrapersonal and interpersonal losses generally occurs in a similar way to the grieving process observed after bereavement and relates to losses of persons, self, identity, a carefree protected childhood, and previous dreams and aspiration. Resolution of intense and insecure attachment conflicts is addressed via providing space and opportunity for the client to feel acknowledged (mirroring) and to feel connected to a protective and idealized other (idealizing of therapist via self-object transferences) (Kohut & Wolf, 1978).

Stage 3: Reconnection

This stage focuses on personality re-integration and rehabilitation, on reconnecting with self, others, and the world. Due to increasing empowerment of the client, twinship transference is common in this stage (Kohut & Wolf, 1978) enabling the client to feel a sense of affiliation and one-ness with a benign other (therapist), also conceptualized as *mutuality* by Rogers (1980), which requires a reasonably stable and coherent self. The therapist continues to support the client in his / her attempts to live an increasingly functional life, by supporting movement towards increased autonomy and intimacy (van der Hart et al., 2000). Current relationships, including the therapeutic relationship, are reflected upon and explored in terms of *old* and *new* patterns of relating. Significant

empowerment of the client and increased intentional and self-motivated client participation regarding therapeutic movements, progress and goals of therapy usually become apparent during this stage. Awareness of the client's struggles to reconnect with reality, meaning his / her capacity to tolerate change (and the speed of it), and the "management of normal vicissitudes of daily life" (van der Hart et al., 2000, p. 11) are of utmost importance to prevent relapse into old patterns and defenses. Existential and spiritual issues are usually arise and are addressed during this phase. Recovery is a process that may take years and may involve additional top-up sessions or return to therapy during particularly difficult life events or developmental stages in later life (Wilson et al., 2001).

2.4.5 Limitations of a Holistic Psychodynamic Treatment Approach

It is difficult to sustain this kind of long-term treatment in resource poor environments or 'outcome based' short-term focused managed health care.

Beyond being aware of the treatment phases, there is no clear or cleanly defined generalizable plan of stepwise actions, as opposed to the treatment schedules and manuals of exposure-based CBT approaches. Therefore, the therapist is more likely to experience anxiety due to uncertainty caused by being in the therapeutic situation rather than orchestrating it, and the resultant fear of making wrong therapeutic decisions may be intense and paralyzing. This may also lead to (perceived) lack of accountability or to omnipotence-feelings and over-involvement by therapist, also termed Type II transference (Wilson, Lindy & Raphael, 1994).

How does the therapist really know what the client needs? This question is particularly relevant if the client is extremely disorganized and fragmented. The psychodynamic conceptualization of complex trauma as well as its treatment approach does not provide specific answers regarding interventions and outcomes, nor regarding timelines (due to each client's unique configuration of symptoms, as well as current and premorbid functioning), and this may confuse inexperienced therapists, particularly those who have not worked with trauma survivors before. For this reason, the Department of Veterans Affairs' Clinical Treatment Guidelines for PTSD recommend that only experienced therapists treat clients suffering from complicated and complex trauma. Klein? and

Paviae (1999) disagree and argue that even therapists inexperienced in treating trauma may achieve good results as long as they are highly motivated.

Though the approach outlined above may be helpful and effective for clients suffering from complex trauma, due to the intense involvement of the therapist, who has to engage fully, congruently and authentically as a person to assist the client on his journey, vicarious traumatization and burn-out due to emotional exhaustion is a strong likelihood (McCann & Pearlman, 1999; Rothshild, 2002) and may lead to therapists 'pulling out' and ceasing to work as therapists, or ceasing to work with trauma survivors, or being available for fewer clients. This approach also requires some amount of intuition and willingness to engage that cannot simply be learnt but needs to be based on the therapist's own worldview and life philosophy.

Research studies of psychodynamically based therapy with clients suffering chronic or complex trauma are few (van der Kolk, McFarlane & van der Hart, 1996) and often appear less successful than exposure treatments, especially when compared with those survivors immediately treated after a once-off traumatic event (Department of Veterans Affairs, 2006). This may be due to the difficulty in evaluating psychodynamic and relationship-based therapy quantitatively, especially when it focuses on changes that are not as readily quantifiable, such as rehabilitation or development of the client's self. Commonly, evaluations are based on quantitative measurables rather than complex and contextual individual experience of quality of life. This may confound results due to the significant variations in the presentation of the complex trauma syndrome and its healing, which is not easily expressed or measured quantitatively.

3. Methodology

This chapter serves as a brief outline of the rationale for employing the single-case study method in this study. It delineates the process through which the case is explored phenomenologically, using psychodynamically based therapy as a qualitative research method.

3.1 Qualitative Methodology

Qualitative methodology is an excellent tool for in-depth exploration of critical conversations and process between therapist and client. It allows the researcher to work phenomenologically, to "allow the phenomenon to disclose itself, to speak to us […] in all its possible profiles" (Kruger, 1986, p.191). The therapeutic method employed in psychodynamically based psychotherapy is conducive to the development of knowledge due to the "intensive study of individual cases which may give comprehensive understanding of individual development, the open mode of observation [which] makes possible the discovery of unexpected phenomena, the interpretation of meaning [which] gives access to a depths of knowledge of human existence, the historical dimension [which] gives an extraordinary temporal context for the formulation and testing of interpretations, the human relationship of the therapeutic situation [which] involves the trust necessary for a disclosure of the deeper levels of personality, [and] pathology as a subject matter provides a magnifying glass for normal behaviour" (Kvale, 1986, p.167).

This close and detailed observation of a single case in great depth may assist in either exploring or adding to established theory using a specific, particular case focusing on the subjective experience of client and / or therapist in the therapeutic process. Qualitative research locates the observer in the world, that is the therapeutic relationship, and uses a set of interpretive practices (for example recorded case notes) that make this world visible (Denzin & Lincoln, 2000). This is well possible within the frame of psychotherapy, which takes place within a self-reflective framework, as does phenomenological research (Kruger, 1986).

Understanding is considered central to qualitative research versus *explaining*, which is more characteristic of quantitative research. *Understanding* lends itself to more in-depth and open-ended process, which allows for the examination and exploration of nuances and subjective experiences (Elkon, 2004).

An empathic stance that is facilitated through "thick description" (Stake, 1995) permits the reader empathic entry into the case. This foregrounding of empathic relating and understanding in the qualitative case study advocates prudence regarding a search for fixed causes to human behaviour (Dilthey, 1994 in Stake 1995), since the focus tends to

be rather on the complexity and singularity of the case at hand. This, however, does not categorically exclude possible application of findings to other similar cases.

3.2 The Case Study

A case study is "a case-based research project that examines a single case, usually in considerable depth" (Edwards, 1998, p.37). It is an "ideographic research method, which studies individuals as individuals rather than as members of a population" (Lindegger, 1999, p. 255) and it is "normally descriptive in nature and provides rich longitudinal information about individuals or particular situations" (ibid.). As explored above, a case study is usually qualitative in nature.

3.2.1 Strengths of the Single Case Study

The case study method "has played a central role in clinical and developmental psychology" research (Edwards, 1993, p.1). It is an 'old' research method with regards to examining psychodynamic theory, because "in the field of psychotherapy, careful and systematic observation and description of individual cases has been the cornerstone on which the development of scientific knowledge has been built" (Edwards 1998, p.10).

Single case studies are often used by clinicians to evaluate the efficacy of their interventions with single patients (Lindegger, 1999) since this method allows for in-depth insight, based on rich information due to good rapport with subjects / clients, which are mostly familiar with the researcher / therapist and therefore likely more inclined to entrust him with sensitive and expansive details than a once-off, neutral or objective researcher. To achieve such depth, the researcher / therapist needs to enter into a "patient communion with the phenomenon to let all its dimensions emerge" (Kruger, 1986, p. 201), that is to let the therapeutic process unfold itself without intentionally steering it theoretically or practically in a particular direction, trusting and following the client on his journey, witnessing it, and simultaneously reflecting on it as well as his own responses to the observed progression.

A single-case study design also proves helpful when one wishes to test a theory or approach in an exceptional context (Kelly, 1999), or explore why therapy is 'ineffective',

such as in treatment resistant cases, or if one wishes to explore and document “critical” and “extreme” cases (Yin in Robson, 1993). This could be expanded to cross- cultural exploration or verification of theories or treatments, since it could assist in promoting critical reflection on existing theories as well as allowing new ideas and hypotheses to emerge from careful and detailed observations (Lindegger, 1999).

Case studies are also especially useful when describing the context within which an intervention has occurred and to attempt to explain causal links which are too complex (or novel?) for surveys or experimental designs. Therefore, it can be argued that case studies are useful starting points when exploring and describing new or multi-facetted phenomena. Many important, complex real-life problems cannot be studied more effectively by experimental methods of enquiry (Edwards, 1993). The retrospective description of complex phenomena may subsequently lead to new ways of looking at theories and situations and so encourage more research. It must be noted, however, that “the quality of the case study depends to a large extent on the quality of the investigator” (Robson, 1993, p.162), who is the primary tool in this method of enquiry.

3.2.2 Limitations of the Single Case Study

Non-standardization of measurement is generally considered a limitation of the case study, since it complicates if not prohibits the replication of the study and therefore problematises the assessment of the validity of information gained (Lindegger, 1999). However, Edwards (1993, p.1) argues that adopting such a quantitative, measurement oriented, positivist research ideology in clinical psychology is “severely handicapping” because it uses “mathematical relationships as the basis for predicting and explaining human behaviour” (ibid.), which he considers inappropriate because “there is too much distance between the realities of psychological life and the mathematical models of multivariate statistics” (ibid.). Kruger (1986, p.193) concurs, arguing that generally applicable “psychotechnologies” and research strategies aiming at such, are the exact opposite of the in-depth understanding of phenomenology, which holds that human experience is complex and needs to be understood individually and in context. Kruger (1986, p.201) adds that “in psychotherapy, numbers in themselves have no disclosive power whatsoever. Human life allows itself to be disclosed through explicating qualities”.

Therefore, causal links are also difficult to test in a single case study (Lindegger, 1999), because information (data) obtained is highly specific, subjective and complex. It lends itself to in-depth exploration and description of phenomena rather than to pronouncements of their specific relatedness.

The fact that generalizations cannot realistically be made from single case studies (Kvale, 1986; Lindegger, 1999) is frequently seen as a shortcoming of this method. However, case studies are more often than not conducted to illustrate an existing theory or framework or to explore new avenues, and therefore generalization of findings is not an envisaged outcome. The raising of questions and adding of information to existing theories, knowledge and practices is the more prevalent and more realistic aim of the single case study. There is also the possibility that a number of case studies on a similar problem with different clients over a longer time period may bring out or highlight patterns or trends that may well be generalizable.

Criticism has also been leveled against the embedded researcher, as found in the single case study method, which involves only the subject (i.e. client) and the researcher (i.e. therapist) (Kruger, 1986). This active involvement of the researcher might be seen as influencing the validity of the information via gatekeeping, specific inclusion / exclusion of information, or steering the process into a desired direction. However, the inclusion of the researcher as main tool of research and also participant in the therapy process may yield important subjective insights regarding the therapeutic relationship and its movements, rather than merely the client's perceived or reported experiences and may lead to greater depth due to the high level of trust in the therapist / client relationship (Kruger, 1986; Kvale, 1986). Concepts such as transference and countertransference for example are essentially only accessible to research in this subjective manner. It is also questionable if the perceived neutrality of the quantitative researcher is really objective, and if one can ever truly be said to be 'outside' the research process, even when employing quantitative methods.

3.2.3 Case Study and Trauma

"Individual case reports comprise the bulk of the psychodynamic literature on the treatment of psychological trauma" (Dept. of Veterans Affairs, 2006), which may well be due to the extremely individual and *subjective* experience of psychological trauma, particularly chronic complex trauma, which is not easily explored with standardized quantitative methods.

Another reason for using the case study method lies in the complex and multi-layered conceptualization of trauma, which was selected for this study. It includes aspects such as alterations in affect, alterations in perception of self and alterations in relating to others (Herman, 1992), which are very subjectively understood and experienced concepts. These are best explored in a qualitative subjective manner to enable a detailed and in depth description of the client's as well as the therapist's unfolding experience of complex trauma and the therapeutic interaction that constitutes treatment / intervention.

3.2.4 The Current Case Study

The participant of this study was selected via convenience sampling, that means the participant was accepted as a client and therapy was conducted without the intent to formally document the case as an academic paper. Only at the end of the initial year of therapy this possibility was discussed and decided upon. Written consent was given by the client.

Therapy was conducted over 96 sessions of an average of 60 minutes each, from 10 March 2004 to 24 November 2005. There were a number of double-time sessions of 2 hours each, and a number of shorter emergency or crisis sessions of 20 to 30 minutes.

Initially, therapy was experienced by the researcher as a rather unstructured and overwhelming process and supervision time was taken up almost solely by this case. This was complicated by the client being a 'designated Person Centered Therapy Client' for the purpose of training. The supervisor, however, was guiding from a psychodynamic framework, which the therapist had not previously been much exposed

to either theoretically or practically, due to this not being the prevalent theoretical approach at Stellenbosch University Psychology Department at that time. The conceptualization of the case became more coherent for the researcher after Herman's *Trauma and Recovery* (1992) was recommended in psychodynamically oriented supervision and became a guiding framework to contextualize and organize meaning in the therapy process and the therapeutic relationship. The therapeutic intervention continued based on client-centred strategies, but with a psychodynamic conceptualization in mind.

A number of issues and process movements, which can be described in terms of a shift in organizing principles in both client and therapist, only crystallized in the therapist's mind from midway into the therapy process and even more so afterwards. The applicability of Herman's psychodynamically based treatment approach was not attempted to be proved but rather 'proved itself' to be useful in this case of treating chronic complex trauma. The importance of the relationship in treatment was recognized as treatment unfolded but was not initially conceptualised as the treatment tool as such.

This case study describes and explores the subjective experiences generated in the intersubjective field of the therapeutic encounter by both client and therapist

The experience of working with complex trauma was a process requiring a persistently self-reflective attitude from the inexperienced therapist to remain open to the situation unfolding itself, including a multitude of shifts in meaning and process. The endeavor was to achieve "a dialectic of closeness and distance" (Kruger, 1986, p.201), that is to get close enough to the client and deep enough into the relationship to let its dimensions emerge and unfold in its multi-facetted ways, yet also to establish sufficient distance to contemplate, reflect on and discuss the phenomenon of the therapeutic process.

The awareness of and engagement with both transference and countertransference posed a continual essential challenge. This case study reflects the shifts from fragmentation to greater coherence in both client and therapist, which developed through and within the therapeutic relationship.

3.2.5 Data Management

Extensive, detailed therapy notes were written up after each of the 96 session throughout the 20 months of therapy. Video recordings were made additionally to the notes for the first eight months of therapy, which was conducted at the Student Counseling Centre at the University of Stellenbosch.

During the second year of therapy and after discussing the writing up of the therapeutic process in the form of a thesis, the client unsolicitedly supplied the therapist with her diaries for the past two years, as well as other essay type notes on how she had experienced therapy. She stated the wish to have her case heard and seen fully from all sides so that it could be documented appropriately, and also to 'detect missing links'. Both the therapist and client may be regarded as the primary 'tools' in research process regarding the generation, gathering and selecting of material / data.

3.2.6 Data Analysis

In line with the phenomenological approach, openness for all aspects of the phenomenon - the psychotherapeutic relationship in the treatment of complex trauma - has been aimed for, so as to better understand the organizing principles underlying this therapeutic process. Via the "process of intuition, reflection and description" (Kruger, 1986) the researcher gradually acquired a sense of the whole complex interaction as experienced and described. Secondly, patterns and themes were extracted by "breaking up material into natural meaning units" (Giorgi 1971, 1975 in Kruger 1986), subsequently these themes and their shifts and changes were formulated psychologically and evaluated in relation to the whole phenomenon, that is how these themes make sense within the process of healing.

The evaluation and explication of selected themes within the larger frame of the phenomenon (the healing process) is situated within the chosen theoretical psychodynamic frameworks outlined above, to arrive at an essential structure of the experience via synthesizing and integrating insights obtained from the explication of the various themes in their context (Giorgi 1971, 1975 in Kruger 1986; Giorgi, 1985). To

illustrate this process, the most prevalent and case representative examples were chosen to be unpacked in the discussion section.

The emergence and selection of themes involved both researcher and client. It was influenced by what each considered important and brought to the intersubjective context. Therefore it cannot be said that the researcher selected themes and material 'objectively'. The intersubjective interaction, the relationship between client and therapist, is the central focus of this qualitative exploration of the healing process, and simultaneously a precondition for it, since phenomenological research outside a relationship of trust is not possible (Kruger, 1986).

3.2.7 Validity / Reliability

The "intensive, largely retrospective study of individual cases can be as rigorous and informative as the extensive, prospective study of samples of people, whether in survey or experiments" (Edwards, 1998) and generally has a good external validity since theory has been examined in a 'real' situation (true therapy) and not an experimental set up.

Internal validity refers to any claim that a causal relationship between variables has been demonstrated. This is particularly difficult to substantiate in a case study and depends largely on the quality of the researcher's argument.

Any argument naturally depends on the quality of the data collected. It is essential that data be genuine and free from selection effects (Edwards, 1993). This is particularly problematic when dealing with self-reports, as included in the material of this study. One also needs to take into account that data needs to be used selectively to condense it into a coherent paper, which by itself constitutes a subjective selection process by the researcher / therapist.

Quantitative data regarding the intrapsychic processes of a client is by its nature very hard to come by, but there are few limits to the wealth of detailed information about the therapy process and the client's (and therapist's) *subjective* experience of it. This then places the researcher in a position to "show how therapy has set in motion and

facilitated a recognizable and meaningful process of healing and integration" (Edwards, 1993, p.17-18) as is the aim of this study.

3.3 Ethical Issues

The writing of the thesis was discussed with the client and her written permission was obtained. The client requested that any identifying details, such as name and place of origin be changed. This was done. She did not request any other changes or placed limitations on the content. In fact, she supplied me with some of her own writings regarding her feelings, thoughts and process throughout the time she spent in therapy as well as on the therapeutic process itself.

The client expressed excitement at being able to "give back" or "pay back" in a tangible way for what she perceived to be "two years of free therapy" and stated that she wanted to assist the profession in documenting what had "made therapy work" in her case. She felt that her condition had subjectively improved and wanted this experience to benefit others in her initial predicament.

It is important to note that the client participated actively in the process of documenting therapy via unsolicited provision of diaries, writings, and commentary. It could be argued that the client harbored the desire to have her difficult struggle / journey, and achievement documented and validated. This desire may also be based on a need to have her personal struggle witnessed via the documentation of her case.

It may seem problematic or controversial that the client participated so actively in the documentation process, because this might have led to her selecting only specific material to be included / excluded and may therefore have led to a very subjective and narrow or at least tainted picture of the process. However, even such a possibly very subjective selection provides the researcher with valuable information on the client's focus, processes and perceptions, and therefore adds to the depth of the study as well as extending the empowerment that occurred in therapy to letting her voice be heard distinctly in the documentation of her case.

4. Case Study

To place the symptoms, therapeutic interventions, and therapeutic changes into context and to allow a detailed and in-depth unfolding of the process and its complex dynamics, a comprehensive history of the client and therapeutic intervention is provided, since "[i]t is exactly by looking at the phenomena presented by the client and by tracing these historically that we can come to understand the client" as well as the healing process (Kruger, 1986, p. 203-204).

4.1 Case History and Description of Client

4.1.1 Intake, Presenting Problem, and History of Presenting Problem

Intake

Silke is a 23 year old, single, Caucasian, Afrikaans-speaking student in the Faculty of Humanities (3rd year level) in her sixth year of study at this university. She had previously been diagnosed with treatment resistant Major Depressive Disorder (chronic) by her psychiatrist and prior psychologists.

Presenting Problem

Silke contacted the crisis service of the university at 11h45 on a Sunday, complaining of anxiety and sleeping problems ("Ek kan glad nie slaap nie.") and making an urgent appointment for the same day. She reported feeling very lonely and unable to sleep due to nightmares ("Ek is baie alleen en die verskriklike nagmerries wil my nie laat slaap nie"). She appeared anxious and disheveled when she arrived.

History of Presenting Problem

The current complaints (nightmares and sleep disturbances) appear to have started during Silke's childhood and have persisted into adulthood. She has self-medicated with sleeping pills, and was still doing so when therapy commenced. She received pharmacological and psychological treatment for Major Depressive Disorder of which the sleeping problems were assumed to be a symptom. Various anti-depressants had been prescribed over the past 6-7 years. At first presentation she was using Effexor, an antidepressant, and Topomax, a mood stabilizer.

She reports that the nightmares occur every night and that she sleeps better during the day, which leads to her missing classes resulting in academic problems, which in turn create more anxiety and conflict with her parents, which leads to periodic attempts to seek help at the crisis service. Silke uses the crisis intervention service of the university up to twice a month, often at night. This presentation was one of those occasions. She always presents with the above mentioned symptoms. This behaviour seemed to persist while she was in individual therapy previously.

It appears that Silke uses the crisis service for symptom relief, to combat loneliness and insomnia. She reports that the past attempts at long-term therapy 'were helpful', yet her pattern of symptoms and crisis intervention does not seem to have changed significantly over the years (according to patient file).

4.1.2 Family History and Personal History

(See Appendix B for a summary)

Silke's family has a history of multiple suicides, extreme violence and emotional as well as physical neglect (see Appendix A). Her father experienced sustained physical and emotional abuse and neglect in his own childhood. He is reported to be emotionally unstable, more markedly so after an operation to remove a brain tumor in 1999. He is an invalid living on a pension. According to Silke he sometimes "sit net so en maak snaakse geluide and dis baie scary vir my". He has been a regular user of sedatives for at least 7 years. He is reported to have made repeated suicide threats, which involve locking himself in the garage with the car engine running and the family worried and helpless outside. The paternal grandmother had exhibited a similar pattern, discharging a gun after threatening suicide, eventually not harming herself, yet traumatically frightening Silke and her sister.

Silke's mother has a similar history of severe abuse and neglect in childhood. She was later placed with foster parents, who eventually both committed suicide. The way Silke describes her mother reveals an emotionally immature, uncontained person whose own needs were rarely met and who tried to have them met by her daughter. She married Silke's father due to an early unplanned pregnancy with Silke's older sister and is apparently being reminded of this by her husband frequently in a very negative manner.

She placed Silke in the role of her confidante from a very early age, sharing inappropriate information with her and showing great distress when Silke voiced feelings of overload and not wanting to carry her mother's burdensome intimations. Her mother's lack of understanding for her needs and resultant negative response induced great guilt in Silke, who resumed her 'duty' as confidante and developed more and more into a "parentified child" (Jurkovic, 1997) in this role reversal. The mother's frequent shifts between disempowering overprotectiveness and overpowering emotional demands created initially confusion, later great ambivalence and guilt in Silke who felt she could never live up to what was expected of her.

Silke, her mother, and older sister are described to have formed an alliance against the father who is perceived as violent unpredictable outsider by them. This does not mean that the three form a harmonious unit. Silke's relationship with her sister is saturated with tension, anger and a feeling close to repulsion. This was assumed to be due to the fact that it was her sister's boyfriend who raped Silke during her matric year, but Silke clarified that even before that event they had great difficulties relating to each other. Silke put it down to disparate characters, with her always trying to please and her sister being "rebellious" and "intrusive", invading Silke's privacy frequently and leaving home for overseas soon after matric. Silke reports being repulsed and disgusted when her sister touches her or sleeps in the same bed.

Silke's herself describes a lonely, isolated childhood with pervasive neglect, particularly emotional neglect. She reports escaping into a vivid and at times scary fantasy world in which she lost herself. Her description of these 'escapes' is reminiscent of self-induced dissociation. She reports a myriad of somatic and other problems since early childhood, such as enuresis until Grade 6, insomnia since early childhood ("vanaf ek kan onthou") due to night terrors and nightmares; a pattern of diurnal hypersomnia, which was accommodated by her mother, who took her to kindergarden or pre-school "waneer ek wakker geword het" often mid morning. During her primary school years she regularly came home to an empty house with no food and lived on ProNutro, which seems to have become a comfort food for her, as well as the initiating her erratic eating patterns. Self-care, including regular bathing was not encouraged. Her description portrays a child with very intense and chronically high levels of general anxiety. She was easily fatigued and reports she preferred to "tune out" and sleep to avoid social interaction she found

anxiety provoking and strenuous. This pattern was also prevalent when entering psychological treatment.

Silke enjoyed school and reports having been a good student. She attended a dedicated arts school. At age 9 she had a hip operation, unaware of the reason for it. She reports that she was still immobile in a plaster cast when she was molested by a mentally disabled young man on a family holiday. She was unable to escape or prevent the abuse and disclosed it only years later to her parents who did neither report it, nor respond to in any supportive manner.

In Grade 11 a cluster of symptoms commenced without apparent external precipitant. It included bulimia, extreme fatigue, anhedonia, concentration difficulties, physiological symptoms of depression, self-mutilation by way of cutting (to which she admitted only at a later stage in therapy). During her matric year (Grade 12) she was raped by her sister's boyfriend and the above symptoms increased severely after that incident, which was her first ever sexual contact. She subsequently disclosed the incident to her parents and experienced an extremely negative reaction from her father, who called her a whore and violently but temporarily threw her out of the house. Her mother argued against reporting the case and it was eventually 'hushed up'. Subsequently, Silke made her first suicide attempt by means of a sedative overdose, using her father's sleeping pills. She was hospitalized and Prozac was prescribed by the treating psychiatrist, which she used for a number of years. The para-suicide attempts continued over the years and appear to be an attempt at numbing as much as escaping rather than full intent on death itself.

Silke reports having rarely ever received any praise from her parents, but complaints and reprimands were frequent, even in positive situations such as winning awards at school. There appears to be a habit of double bind communications in the extended family, where no-one ever says what they mean, but rather the opposite, and meaning has to be inferred. This has placed enormous strain on Silke who felt that she was on the one hand totally caught up in it but also felt that she often did not understand what was going on and "got things wrong". The family in preoccupied with social standing and "what people say", which intensifies to double level communication for the sake of "being nice" and keeping up appearances. Confusion, ambivalence and lack of a valid "reality

check" were the results, leaving Silke unsure and confused as to the meaning of interpersonal communications inside and outside the family.

After worse than expected matric results due to the trauma experienced, she made a haphazard and unassisted choice of an inappropriate university course (sports instead of art) "om so ver moontlik van die huis af weg te kom". She reports feeling "out" in her class but enjoys practical work, such as offering physical movement classes at a home for mentally disabled people. This may represent an attempt at gaining mastery over previous trauma, a strategy which according to van der Kolk and McFarlane (1996) proves mostly unsuccessful.

From the onset of her studies she experienced problems with attendance of classes, had frequent and regular occasions of diurnal hypersomnia, missing appointments and exams more often than not, being regarded as totally unreliable and being strongly aware of it but unable to change the patterns. Due to non-attendance and missing exams she has already taken double the time allocated for her course.

Silke has significant problems with interpersonal, especially intimate, relationships. She has had one very supportive boyfriend who finally ended the relationship after approximately a year, after finding Silke's suicide attempts and continued sedative abuse unmanagable. She finds it difficult to set and maintain personal boundaries, difficulties with expression of sexuality, with regards to identifying own wishes as opposed to pleasing others, and continues to have several high risk sexual encounters with strangers, mostly when intoxicated with sedatives and alcohol.

She exhibited a strong sense of foreshortened future, as is common in abused or neglected children (Terr, 1999) and describes the concomitant anxiety as follows: "Ek het maar altyd gedink ek gaan nie ouer as 23 raak nie … nou is ek 23 en weet nie wat nou nie …" and seems at a loss on how to cope with this. Silke struggles to identify, name and managing emotions. They are mostly repressed with sedatives or non-verbally expressed (regression, crying, substance abuse, passive aggressive actions), rather than verbalized or consciously experienced as accompanying an event or thought. This separation or dissociation between affect and event, as well as the inability to name

her own feelings may warrant the description of alexithymia (van der Kolk & McFarlane, 1996).

In 2002 Silke's favourite aunt, her mother's sister, committed suicide. Silke was highly distraught, became dysfunctional, and was hospitalized soon after, following a dissociative episode, possibly sedative induced, during which she drove 50km to the next town and back without recalling the trip. ECT treatment (5 sessions) was administered which she found helpful, and Seroquel and Topomax were added to her current antidepressant Effexor. Her adherence is sporadic. She frequently requests and uses Ativan prescribed by her psychiatrist which is intended for anxiety relief before exams. However, she generally used all pills at once, then sleeps through the exams, repeating her childhood escape pattern when life becomes demanding and strenuous.

She has been in therapy for over 3 years with various psychologists, has been exposed to a wide variety of therapeutic modalities and techniques due to mostly being seen by enthusiastic but time limited M1 clinical psychology students, and has herself studied undergraduate psychology courses as part of the requirements for her degree. She reports finding therapy helpful but attendance appears to have always been sporadic.

She continued to exhibited passive suicidality (driving under the influence of alcohol and severely sedated) and episodes of dissociation (possibly sedative related) as well as severe neurological symptoms and paranoia (persecutory).

Silke appears to be the 'identified patient' (Gale Encyclopedia of Psychology, 2001) in the family. Family members focus mostly negatively on "Silke se depressie", either in an overprotective or a judgmental way, complaining about her lack of willpower to change her life, her being a financial burden to family, and the worry she is causing everyone.

4.1.3 Initial Diagnosis

DSM IV-R:

Axis I MDD (chronic, severe, without psychotic features), treatment resistant
Insomnia related to MDD
Bulimia Nervosa, purging type (remission)
Substance Abuse (sedatives)

Axis II Borderline Personality Disorder Traits
Dependent Personality Disorder Traits

Axis III None

Axis IV Academic problems
Financial problems
Social support / family problem

Axis V Current GAF: 32
Highest GAF in past year: 50

Re-reading and exploring all material for the purpose of this paper, the question arose why no anxiety or PTSD diagnosis was made, though it was noted on the initial intake form that both her mood and affect were congruently and visibly anxious, and that PTSD was “a possibility”. Was that a case of conveniently and anxiously falling into step with the very real, long term main diagnosis of chronic depression, a label she arrived with and that was confirmed by all prior clinicians treating her? This initially unquestioning acceptance of the existing diagnosis greatly contributed to the complex and difficult path to more coherently recognizing and addressing the causative trauma and its resulting defenses and coping mechanisms, such as the tenacious depression, in a constructive way.

4.1.4 Alternative Diagnosis and Formulation

Diagnosis according to Herman's (1992) conceptualization of complex trauma:

> Complex Post Traumatic Stress Disorder expressed via Major Depressive Disorder, Borderline Personality Disorder, various related symptoms (nightmares, neurological and psychosomatic symptoms)

Formulation:

Silke L. is a Caucasian, single, 3rd year Humanities Student in her early twenties. She is in her sixth year of study at this university. She presented at the psychological services on 10 March 2004 complaining of anxiety and sleeping problems and requested an urgent appointment for the same day. She reported feeling very lonely and unable to sleep due to nightmares. She appeared anxious. She had previously been diagnosed with Major Depressive Disorder (chronic, treatment resistant) by her psychiatrist and was put on treatment (anti-depressant, mood stabilizer), which she currently using with varying adherence.

Silke presented somewhat disheveled, with her hair and clothes unwashed. She came across as an anxious and tired young women with a child-like quality about her. Her request for assistance is made in a resigned and almost apologetic voice and there seems to be little faith that she can be helped. Yet there is also a defiant and demanding undercurrent in her approach, which she seems unaware of. She appears to know the intake procedures at the Centre and provides information about herself fluently, repeatedly dissolving into tears. Her narrative has a much-repeated, distant quality about it. Yet the loneliness, hopelessness and emotional pain she feels are palpable and seem imprinted on her very expressive face, somewhat in contrast to the emotionally flat reporting of repeated trauma.

To aid with an understanding of the difficulties Silke presents with, it is useful to consider the following factors and how they intersect.

Predisposing factors include Silke's childhood in a family with a volatile, at times violent father and a fairly helpless, enduring mother. Neither parent was able to be emotionally

available for Silke, most likely due to their own deficits as a result of insufficient mothering in their families of origin. This led to Silke being frequently and chronically physically and emotionally neglected. In addition she had to fulfill a mothering role with regards to her own mother who saw a confidante in her and burdened her with problems and responsibilities far beyond her capacity, unsuitable for a child and young girl. She lacked care, nurturing and protection in her early years and had to face traumatic experiences (molestation, rape) unsupported. Not only did she not receive support, she was actively discouraged from recognizing and working through trauma by her primary care givers, who encouraged denial and avoidance.

This appears to have led to her viewing the world as a dangerous, unpredictable, unhelpful place and this negative perception of the human condition as well as of herself is maintained by her social isolation and lack of effective coping skills and a support system. She reacts to trauma and emotional problems by avoiding them by means of sleep and escapes into a dream world (altered states on consciousness).

From a self-psychology perspective, it can be hypothesized that Silke has not had the opportunity to have her innate sense of vigour, greatness and perfection mirrored when she was a child, since both her parents were emotionally unavailable and the father sabotaged her efforts at 'being good' and performing (as the quiet child and peacemaker, scholastically) by ignoring and belittling her. Due to her position as confidante for her mother she also missed out on an idealized parental imago to whom she could look up to and merge as an image of calmness and omnipotence. It rather appears that it was Silke, the child, who was designated to fulfill (and to an extent still fulfils) this role in the family. The lack of optimal interactions between her and her parents has placed and maintained her in a position that was unsuitable and overwhelming for her as a child and has led to perpetual experiences of being unsupported and being incompetent and a failure.

This has resulted in Silke not having the opportunity to develop an autonomous coherent self via transmuting internalization because her self-objects (parents) were neither consistently responsive nor empathic, and did not respond to her experiences repeated trauma and mistreatment. She appears to have developed a rather enfeebled self, lacking vigor and self-esteem, having low expectations of herself, her skills and abilities

and being unable to effectively self-soothe or plan for the future. Additionally she uses defense mechanisms of avoidance and denial, projection and regression to cope with excessive anxiety brought on by situations she feels cannot control (for example nightmares, exams, intimacy, relationships).

To assist Silke, individual supportive psycho-dynamic psychotherapy was recommended to provide the regularity, reliability and attentiveness she has not received consistently enough in childhood. A supportive, safe 'holding-environment' will allow for the building of trust over a longer period of time and meanwhile assists in maintaining self-functioning with a lesser use of ineffective coping mechanisms. This supportive, not performance oriented, approach includes a variety of therapeutic techniques to be used once safety and basic trust have been established and can be tailored to Silke's specific pace and needs, and so maintain her precarious functioning. The centrality of the therapeutic relationship and the empathic attunement of the therapist are of cardinal importance since idealization-transference and mirroring-transference need to take place in the therapy situation to repair the early developmental arrests and deficits caused by "inadequate mothering" that have led to her current feelings of emptiness, fragmentation and impoverishment, as displayed via her depression, low self-esteem, anxiety, social isolation and ambivalent relationships.

The relationship with the therapist may be the first example of the possibility of establishing gratifying relationships with others. However, one needs to keep in mind that Silke has been in therapeutic relationships before, yet still maintains the same symptoms. Therefore one needs to look out for transference of her low expectations of herself onto the therapist and her subsequent (possibly passive) rage when the therapist responds (as her primary care givers did) with taking control, trying to direct her instead of just providing a safe space. This poses a great challenge to a mental health professional who is conditioned to 'help', not to do what feels like 'standing by and looking on'.

Silke's inherent, yet suppressed creativity and agile imagination as well as her (yet passive) rage when control is taken from her may be ameliorating factors, that can be usefully included in later stages of therapy once safety has been established and

recovery has begun. Her insight at commencement of treatment was limited due to avoidance and denial, but is expected to improve as defenses decrease.

4.2 Description of Therapeutic Intervention

The client's history reveals that all of her developmental stages (according to Erikson, 1968) and their desired outcomes: trust, autonomy, initiative, competence, identity, and intimacy, have been partly or wholly compromised. The typical defenses used cope with trauma in childhood were present: inward directed rage, dissociation and self-hypnosis, psychic numbing and denial (Terr, 1999).

Trauma effects and resultant defenses were presented in adulthood, that is during time of commencement of therapy, as: Borderline Personality Disorder traits (inability to maintain a relationship, splitting, chronic fears of abandonment, heightened suicidality, affective instability), chronic severe depression, dissociation, substance abuse, and somatic complaints. Silke presented as a refractory case, with ongoing pharmacological treatment for approximately six years and psychotherapy for at least three years. The prognosis, as confirmed by her previous psychologist and current psychiatrist was at most "guarded", indicating that is was in fact poor.

4.2.1 Therapy Statistics

Silke attended 96 sessions of individual psychotherapy over 18 months, starting on 10 March 2004. She missed 14 sessions and cancelled another 7. After her initial call, she made one more crisis line call (May 2004) and an additionally 4 calls to the crisis line (in 2004) to schedule appointments with me after sleeping spells had resulted in her missing appointments. On 30 November 2005, after termination of sessions, she made her one and only 'panic call' to report she could not cope, but having 'touched base' continued to cope well. She graduated in Dec 2005, and then moved overseas.

4.2.2 Treatment Summary

Clinical intervention planning was difficult and initially overwhelming. Silke already had a thick file with documentation of a wide variety of past treatments (psychological and

pharmacological), which led to treatment paralysis in the therapist. A team meeting was called, including Silke's previous clinical psychologist and the psychiatrist, which led to even more paralysis, due to the case being viewed as "quite hopeless".

Initially, sessions were of a purely supportive nature, the therapist absorbing the client's emotional disintegration, chaotic affect, neediness, and unpredictable passive aggressive acting out behaviour. Silke exuded enormous helplessness and demand for nurturing that a wish to reach out and 'mother' and 'fix' her was strongly evoked. The re-counting of the traumas she had experienced made the therapist feel traumatized too and the size of her file, medications and previous treatments was frankly overwhelming. The need seemed too great to fill or even constructively respond to. Feeling debilitated and de-skilled, the therapist did 'nothing', just came and sat there week after week listening to detailed accounts of Silke's life, reflecting occasionally to assist Silke in naming the emotions she acted out, but mainly remaining mute but available and predictable. The impression that 'all had been tried with her already' created the space for "doing nothing", yet feeling neither guilty nor resentful about it, since all the options previously tried had not been successful either. This situation permitted therapist and client to slowly meet each other in the therapeutic situation without rushing and imbued the therapist with the strength and patience to 'sit out' Silke's late-coming, missed appointments and other 'tests' to check if she was going to be abandoned again. It permitted Silke to pace the therapeutic process according to her needs and level of affective involvement she could cope with, as well as allowing for trust to build before initiating or encouraging exploration via interpretations.

It was imperative to remember that it was not advisable to express expectations or give advice to speed up the process when Silke coped more effectively later on, since this was exactly what overwhelmed her and resulted in 'relapses'.

Psychopharmacological treatment with Effexor and Topamax was continued. Initially sedatives and Ativan were discontinued, but later taken up again periodically. In the second year of therapy, Cymbalta replaced Effexor for a few months, Valium, Seroquel, and Zyprexa were intermittently added and she discontinued them voluntarily towards the end of therapy. All medication was prescribed and decided upon unilaterally by the psychiatrist.

4.2.3 Significant Events

The following significant events outline important points in the therapeutic process. The timeline permits a brief overview regarding the chronological order of events, their spacing and pace. The occurrences need to be seen in conjunction with the subsequently listed prevalent themes and therapeutic shifts in therapy to provide a more in-depth backdrop for the understanding of the therapeutic relationship and the client's unique development during the period of intervention.

10 March 2004	Call to Crisis Line and commencement of therapy
June-Dec 2004	Romantic relationship. Silke broke up with boyfriend in December.
15/16 Nov	Mistakenly 150 sleeping pills intended for her mother were sent to Silke's address. Help-seeking and coping activated. Did not use pills.
Sept 2004	Obtained enough credits to write all her exams 2004 (if passing all she would have received her degree, she missed one of them which she had to write in Jan 2005)
Jan 2005	Requesting supplementary exam, vital to obtaining degree.
Jan 2005	Passed the remaining exam in and therewith obtained her degree
Jan 2005	Registered for Higher Education Diploma and worked more consistently throughout 2005
Feb 2005	Obtained employment as waitress
April 2005	Medical hospitalization (unidentified neurological condition)
July 2005	STD / HIV scare and responsibility taking
Oct 2005	Brief psychiatric hospitalization (self-requested, diagnosis unclear)
Nov 2005	Passed all exams she wrote (postponed 2 modules)
15 Dec 2005	Graduation
Nov 05–March 06	Organized herself a paid job for the holidays
2006	Organized employment in the UK, starting 2nd term 2006
2006	Registered at UNISA to complete two above-mentioned modules

4.2.4 Prevalent Themes

The following themes emerged during reflection throughout the therapeutic process and were identified as the most salient themes upon repeated perusal of case notes and transcripts after completion of therapy. Together with the 'significant shifts and changes in therapy', which are briefly explored in the next section (4.2.5), they constitute the "meaning units" (Giorgi, 1985) utilized for a close, in-depth investigation of the phenomenon of the therapeutic relationship as experienced in this particular therapeutic interaction by both client and therapist.

Themes:
Failure and helplessness
Trust
Family relations
Communication on two levels / masks / confusion
Overwhelming and unmanageable emotions
Remembering / Story telling
Ambivalence in relationships
Isolation / Loneliness / Alienation
Outsider vs. insider (identity)
Control
'Normality'

4.2.5 Significant Shifts and Changes in Therapy

This section describes selected shifts and changes in therapy, which emerged during the intervention as well as during intensive engagement with the transcribed material afterwards, similarly to the themes listed above. The shifts in therapy are presented in a descriptive vignette manner to provide a limited experience of those events or changes that are representative for this case, with the aim to provide a backdrop for the discussion of these events and shifts in relation to theory in the next section.

Affect regulation and articulation of feelings

During therapy sessions Silke would initially appear relatively stable until emotions were evoked by current events or via memories. Then she tended to disintegrate. Her mouth started trembling, she started crying and was unable to speak. The appearance and demeanor became that of a young child dissolving helplessly into tears, unable to verbally articulate her anguish. Initially this happened up to three times a session (but at least once each session) from March to June 2004. Upon return from the June holidays a subtle change towards a more 'mature' expression of sadness and crying slowly took hold. Tears were running down her face but she did not 'fall apart' completely and could continue with her narrative and the crying would stop as the story ended. Though the regressive episodes continued, they became less severe and more widely spaced. Silke appeared increasingly more 'grieving' that 'lost', particularly from after the Christmas holidays (that is from the 10th month onwards).

At first feelings could rarely be identified or named, and were mostly acted out or dissociatively avoided. At most they were articulated within a range of "ok", "down", "not good" and "sad", and the identification of any emotions, either by the therapist or later by herself, mostly led to the disintegration described above. After approximately 3 months Silke was able to identify her emotions in therapy (not yet outside) with somewhat more precision and after 5-6 months she arrived with brief narratives she had constructed around events in her life, the feelings they had evoked in her, and her reactions to events and feelings. After about 9 months emotions could not only be identified and named appropriately, but their etiology and nature reflected upon. Affect regulation, however, was still a hit-and-miss affair and much exploration regarding possible coping and planning strategies was done in the last 6 months of therapy. During this time, Silke increasingly related instances where she had been able to reflect on her emotions before reacting to them or disintegrating or dissociating. Verbalized rather than acted out distress predominated from mid-2005. Identification of her own emotions also helped her to interpret others' emotions and intent better and to interpret non-verbal communication more effectively.

Miscellaneous events to focus

At the beginning of therapy Silke would arrive, immediately start talking and continue until the end of session with interspersed crying spells. The content would be a precise description of her past week with digressions into the past and family matters. A disorganized array of facts and events would be presented; apparently for me to 'pick out what was important'. After about 5 months Silke appeared to have achieved consistently more structure and was able to present problematic issues she had identified, instead of presenting everything in the hope that I would pick out what was significant for her. She mentioned that she had noticed this change.

During the last 8 months, she frequently arrived not only with a formulation of 'problems' but with a precise plan of which issues to address during therapy and appeared to have contemplated them deeply before arrival, proposing strategies of approaching and perceiving issues and seemingly seeking perspective and encouragement rather than direction or advice, as had been the case during earlier stages. Self-reflection improved and process reflections were more often initiated by her.

Power shift (empowerment)

With the shift of Silke accepting responsibility for choice of topic in the sessions a shift in her perception of control occurred and she was able to extend that to more assertive behaviour outside therapy, such as starting a relationship and insisting more often on her wishes and needs being met. This reflected also in her taking charge of her studies, including assignments, exams and re-scheduling thereof. It also led to her taking more control / responsibility for the scheduling / canceling of appointments and an increasingly more significant increase in verbalized pride for her own achievements and abilities, such as completed assignments, or standing up for herself when patronized or run down. While Silke was only on time for four sessions during the first eight months of therapy (only 5 minutes from her accommodation), she managed to be on time almost every session during the next ten months, despite a 60 minutes drive to the hospital to attend sessions, after a change of location by the therapist.

It appeared that she was now able to share more positive aspects of her life and more of her current and previous achievements, possibly due to first "having made sure" that her helplessness and desperation had been acknowledged, not minimized, and were being safely held.

Coping behaviour

Silke's coping behaviour diversified, from diurnal sleep, sleeping pills, and crisis calls to options such as postponing instant gratification (buying pills but handing them in, attending class before sleeping) and attempting self-soothing strategies (ginger tea, bathing). These changes were gradual, and old ineffective coping behaviours were still interspersed as well, yet less frequent (sleeping spells rare and never more than one day). Medication was still used as a safety net, but with more forethought and in addition to more constructive coping mechanisms.

During the last half year of therapy she was able to share her feelings and thoughts in an appropriate manner with selected people in her life, who responded positively and also managed to reduce or terminate interaction with 'toxic,' draining friends.

Dissociative symptoms / neurological symptoms

At times of stress Silke continued to report anxiety provoking (pseudo?)neurological symptoms such as 'feeling like not being in my body', 'hearing noises', 'a feeling of things moving very slow and then very fast' and strong anxiety-inducing paranoid ideation: that someone is watching her through pinholes in the ceiling. Neurological investigations, hospitalization, and appointments with the psychiatrist brought no clarity regarding a physical explanation and the symptoms disappeared and re-appeared in direct relation to the amount and intensity of life stressors. Towards the end of therapy she herself made the connection between stress / emotional upset and neurological symptoms. She also decided to stop all medication but Effexor and to use homeopathic drops to combat sleeping problems. She voiced that she "needed to feel that she had taken something" and would then feel much better (placebo effect). She eventually discontinued the homeopathic drops as well after frequently forgetting to take them.

Though her initial regressions in therapy had a strong dissociative quality to them, she never complained of or exhibited neurological symptoms during a session.

It is noteworthy that the decrease in dissociation seems to have increased the neurological symptoms and the decrease of those was followed by an increase in concrete medical complaints, which finally also reduced once anxiety as well as general affect could be more competently managed.

Improved self-care

This was evidenced in her appearance and choice of clothing. She seemed to have maintained and even picked up a little weight in the last 6 months of therapy and reported fewer bouts of vomiting or not eating, despite feeling stressed. This may be misleading, yet her renewed interest in cooking and increased dislike for Pronutro may be a positive sign.

Use of fantasy / imaginary world

The violent content of dreams and self-created fantasies (suffering and perpetrating) decreased. Reported dreams were still vivid towards the end of therapy, but had a less annihilating and horror-movie quality of bloody battles, with severed limbs and eviscerated bodies. There were fewer and fewer images of body parts and fragments and violent incoherent chaos in her dreams, which had acquired more of a coherent 'story', which Silke interpreted and discussed eagerly. This is in stark contrast to the horrifying dreams she initially reported, and which she was unable to discuss or even to assimilate the therapist's tentative interpretations. Discussion of voluntary imagining became possible after about 6 months and evoked cautious excitement about making use of imagination and creativity, an ability she believed lost.

Sleep pattern

The sleep-pattern was initially characterized by insomnia and avoidance of nocturnal sleep due to fear of nightmares, then day-sleep to catch up (sometimes days of sedative induced stupor). The pattern shifted to night sleep with the start of the romantic

relationship half-way in the first year of therapy. Silke managed to get up and occasionally attend morning lectures from that time onwards, and arrived for three morning appointments at the end of the first year. However, she still has sleeping spells in day time and on weekends, when feeling lonely, stressed or upset, particularly during exams.

Planning

A move has taken place from no planning or pure contingency planning to future planning including wishes, ideals and aspirations. This remained a very cautious exercise, fraught with anxiety, until the very end of therapy, but was initiated by Silke. Planning started with a generalized wish to live, after the incident of resisting the temptation of the 150 sleeping pills accidentally delivered to her in the 8th month of therapy, and then specified into more precise and more deeply owned future plans regarding profession, place of residence and personal identity and development.

5. Discussion

In line with the phenomenological approach, the previous descriptive sections served to provide a holistic and comprehensive sense of the history and of the experience of therapy with Silke, extracting a number of main themes by breaking the material into natural meaning units (Giorgi, 1985). This discussion section attempts to explicate three main aspects of the therapeutic experience in terms of their dynamics and essential qualities, aiming to arrive at a situated and essential structure of the experience (Giorgi 1971, 1975, in Kruger 1986), that is to distill the impact of the interpersonal relationship in the successful healing process of the client.

The themes of *self-structure*, *empowerment*, and *transference / countertransference* were chosen to be explored throughout the three treatment phases as outlined by Herman (1992). The use of the staged approach mirrors the treatment progression and serves as a framework to highlight the shifts in the client's behaviour, perceptions and affect as well as the dynamics of the therapeutic relationship. These stages do not occur as discretely separate entities but flow into one another, and the tasks and concerns of earlier stages remain important in subsequent stages. The themes explored

are not separate entities either, but rather a complex process weave. They most appropriately represent the main areas of traumatic damage (that is *self* and *ability to relate*) and the healing process that occurred to restore relative coherence and vitality.

5.1 Structure of Self: Fragmentation to Integration

This section explores Sike's gradual, complex journey from fragmentation to relative coherence and authenticity of self, highlighting patterns in the therapeutic relationship that appear to have contributed to this process.

5.1.1 Safety

Initially, Silke presented emotionally and mentally fragmented, frequently dissociated, lacking trust and vitality. She always expected the worst. The worst for her, she reported, was physical or emotional abandonment. If it occurred in reality or in her perception, it would greatly increase her already strong (yet realistic) feeling and conviction of being isolated, lonely, an outsider, and a failure. To avoid this painful, yet in her emotional world predictable outcome, she would try to lessen the pain and tension of waiting for the 'ultimate crash' by precipitating it, via alienating people, sabotaging care, or by avoiding any emotionally demanding situation, which led to almost total isolation.

This pattern is explicable considering the lack of nurturing in her childhood, the persistently tense and unwholesome family environment and the almost total absence of care givers who could have functioned either as mirroring self-objects to assist her with a sense of pride in her achievements and a sense of mastery, or idealized parent imagos to look up to as examples of goodness and as role models (Kohut & Wolff, 1978). Instead, her parents required her, the child, to mirror their greatness as parents by being a perfect child and taking on adult function, such as being a confidante for the mother. Her parents' empathic failure of not recognizing her, the child, as separate from their needs, severely limited her self-development and denied her the external soothing and mirroring from an idealized adult, which is the base for developing self-esteem, ideals and values, and the capacity to self-soothe (Okun, 1990). The intense and inappropriate

needs of her parents predictably led to a constant sense of failure and guilt in Silke, due to her developmentally appropriate inability to fulfill these adult functions. From a Rogerian perspective Silke had conditions of worth placed on her, which were impossible for her to live up to, and being a dependent child, she naturally sacrificed growth for the sake of approval (Rogers, 1980) and (imagined) security (Yalom, 1980).

Anger was expressed at her, and between various family members but deemed inappropriate when expressed by her, which led to repression of fears, anger, and rage, and the onset of depression after a number of additional traumatic events (such as sexual molestation and rape) during which her parents proved to be both helpless, as well as blaming, rejecting and outright violent towards her, acting out their own helplessness and projecting the aggression born of frustration (Okun, 1990) onto Silke, instead of providing much needed validation (Levy, 2004) in response to her many scholastic and artistic successes (which were instead minimized or ignored). The persons from whom she expected support and nurturing left her to fend for herself, or required her to care for them, which led to such an intense anxiety and deep existential loneliness that dissociation and escape into an imaginary world seemed the only way out. This kind of psychic numbing and dissociation corresponds with Terr's (1999) research on responses of chronically neglected and abused children and Putnam's (1999) explorations on dissociation and trauma. A sense of having given up and having slid into utter helplessness was prevalent during the first few months of therapy and returned at times when emotions became unmanageable.

The loneliness and the escape into an imaginary world is illustrated in her diary entries which repeat over and over the theme of "I dread being isolated and lonely … fear it more than death" and "hoe eensaam ure kan wees al het jy ander mense rondom jou". In one of her agonizingly sober periods, she poignantly and with good insight describes her existential despair:

> "This dark icy whirlpool has invaded the fiber of my very being. My life has slowly succumbed to its chaotic force and it is slowly sucking the energy out of my mind and body. I've tried to escape from it by retreating further and further into the darkest corners of my mind, sometimes assisted by some form of sleeping drug

> … the whirlpool grows ever stronger and my will to fight back hangs by a thread. I feel lost, grasping aimlessly at the fluid, formless mass."

The passage conveys a sense of Silke having lost herself, in the sense of feeling fragmented (Herman, 1992; Kohut & Wolf, 1978), or having lost touch with her *real self*, as described by Rogers in his discussion of the Ellen West case (1980). The powerful and insightful diary passage also illustrates that Silke's advanced disempowerment, disconnectedness and isolation (Herman, 1992) had led to an inability to establish and maintain interpersonal relationships, and that this in turn aggravated her isolation.

Unfortunately, the imaginary world she retreated into could not be controlled either, just as her external world and its occupants could not be controlled, and the imaginary world proved dangerous rather than benign. The sleep she escaped into brought terrible nightmares, filled with severed body parts, screaming deaths on battle fields, sexual images which she found horrifying and repulsive, and her perpetrating as well as suffering this violence. It could be hypothesized that the repressed, unmentionable anger about the neglect and rejection was represented as the powerful perpetrator persona in the dreams, while the emotionally fragmented, lost and abandoned little girl was represented by the victims. The general fragmentation of personae and bodies in the dreams may have represented her general mental and emotional state of disintegration, fragmentation (Herman, 1992, Kohut & Wolf, 1978), horrified despair, hopelessness and lack of trust in her real self (Rogers, 1980), which she had so deeply buried to please others, that she could not access it anymore. Alternatively, one may argue that due to the deprivation and constant threat of abandonment, a true self had in fact never developed due to lack of affirmation of her innate sense of vigour, greatness and perfection (Kohut & Wolf, 1978), and due to lack of nurturing which is essential for healthy attachment enabling establishment of intimate relationships later in life. This pattern is endemic in the family, which may explain why the parents unconsciously tried to get these same unmet needs met by their child.

This history of unpredictability and endlessly repeated experience of loss of even basic support in times of crisis led to a great, almost insatiable need for nurturing, stability, reliability, predictability, and regularity in Silke, which could be summarized as a need for empathic re-parenting (Kohut & Wolf, 1978, Okun, 1990). Expectations and demands,

for example to attend classes or appointments regularly, to do home work or to compile and execute to-do-lists, were unbearable for her and caused her to shut down and escape into sleep in fear of failure. Even these simple daily demands may have caused affective flashbacks of feeling emotionally overstretched and anxious, and were therefore automatically avoided, illustrating the strong connection between past trauma and present benign triggers that is so hard to undo (Garland, 1998).

Supportive therapy (Holmes, 1995), employing largely person-centred strategies as described by Rogers (1980) and Mearns and Thorne (1988), was found to be the only possible therapeutic option, after a few sessions of attempted 'fixing' and exploration, such as addressing her inertia and sleeping spells with cognitive solutions, suggesting to-do-lists and the like. She meekly listened to these pro-active, goal-directed suggestions and then disappeared, only to reappear in a worse state after a week's sleeping spell as if to say "See, that don't work for me!". She reacted to any practical or openly 'constructive' suggestion, which she perceived as pressure, in this way. Passive resistance had been the only manner of resisting unreasonable demands at home and this was played out in therapy too in a habitual manner. In situations like these, where the client 'speaks' with actions rather than words and appears to pointedly frustrate every effort of the therapist to promote healing, it is hard but essential to remain empathic and fully present for the client who seems intent on moving into the opposite direction of growth or improvement (Mearns & Thorne, 1988), often leaving the therapist with a sense of profound inadequacy, puzzlement and frustration coupled with helplessness (Hermann, 1992), which need to be survived rather than fought (Lemma, 2004). This proved to be one of the biggest challenges for this therapist, and improved only once the dynamics could be verbalized rather than acted out in the therapeutic space. Supervision provided a talking-space for the therapist to explore the dynamics of the therapeutic dyad and her own anxieties, and an increasing ability to conceptualize the case psychodynamically (focusing on self-psychology) assisted in understanding the confusing dynamic better by placing them in a more coherent framework.

In the later perusal of Silke's diaries it became clear that she herself had already tried all the 'practical options' suggested, such as motivational songs, poems, movies, to-do-lists, lists of her 'good qualities' et cetera, and that she felt she had failed and that no-one had even seen the effort she made:

> "I am stuck in a whirlpool and struggling constantly upwards against the rage of water for a gulp of air – some arbitrary hug or words uttered, even without conviction, to acknowledge my efforts"

Supportive therapy includes both support in re-living past traumatic experience as well as support in coping with her-and-now events in the clients life (Buirski & Haglund, 2001; Pearlman, 1996). In Silke's case this translated into assisting her to bear the affect of unconsciously re-enacted and re-experienced childhood neglect patterns in the present, bearing the affect of her regressive periods in therapy by providing benevolent presence devoid of demands and pressure, and observing very closely every tiny attempt at mastery and self-initiated change she managed to engage in but which she never 'advertised', for example when she first attempted self-soothing via a cup of tea before drinking all the sleeping pills anyway. The importance of looking out for, seeing, and praising these fragile attempts at self-determination, despite her tendency to minimize and disparage them to pre-empt any possible external condemnation and disparagement cannot be emphasized strongly enough.

The attentive listening and attunement to affect as well as to even minor shifts and efforts was rooted partly in the therapists humanist worldview which values inherent hope in the positive potential of human beings, a quality similar to Medeiros and Prochaska's "optimistic perseverance" advocated for "therapists working with difficult cases" (Mc Cann & Pearlmann, 1999), which led to concerted intent to look for, to perceive, and to help verbalize even her smallest attempts at self-determination and re-vitalization in a reflective manner, so as to help Silke to observe the unfolding of her own self as a creation of herself rather than an imposed, that is 'taught' entity. It was very important to Silke that someone could see and articulate minute changes she had not noticed, or had intentionally suppressed, having experienced much denigration and ridicule in the past for achievements that were found not significant enough to be mentioned let alone celebrated. This is illustrative of the process of the therapist mirroring the client's need for being special, capable and possessing innate potential (Kohut, 1984).

It was extremely difficult for the therapist to just be present, seemingly doing nothing, and to accept that the regular and predictable therapeutic setting and the togetherness in it may be the therapeutic aspect of this intervention, rather than any technique. This finding is well supported by Bion (1980 in Casement, 1991), Holmes (1995), Jacob (1998) & Rogers (1980). The realness of the truly interested, yet also self-contained and (externally) calm yet not 'neutral' therapist; her authenticity in her quest to get to know this client may have been the crucial elements in assisting the client, whose ability to trust and depend had been severely damaged, to develop a sense of safety. The importance and beneficial effect of this kind of therapeutic relationship has been investigated and documented by Herman (1992), Wilson et al. (2001), and Wilson and Lindy (1994).

Clarity in behaviour and communication proved essential to improve safety and to reduce the ambivalence and multi-level, double bind communication she had grown up with and found unbearable and impossible to navigate. Regular appointments at the same time, the same room, and the same session patterns were important to her. Intense affect was experienced as unbearable and continued to lead to regular dissociation and regression in sessions. Interpretation and exploration were therefore not possible because her weak and fragmented self could not sustain such demanding work. Instead, support and maintenance were offered and dependence was permitted in a stable and regular, benign and emotionally nurturing holding environment. Thus a therapeutic situation developed where Silke poured out weekly events in ever more minute details, expecting the therapist to determine priorities and to help her articulate affect which she acted out but found herself unable to discern and name, much less indicate its etiology. This can be understood as severe but expectable affect dysregulation (van der Kolk, 1996) common in survivors of childhood trauma due to lack of opportunities to truly experience mirroring or naming of their feelings (Kohut, 1984), or validation of their organismic experiences (Mearns &Thorne, 1988), but rather being required to present in an inauthentic way (to pretend certain feelings) to please or serve others, to pacify or to ensure relative safety, which in fact summarizes Silke's childhood experiences.

Trust was tested by her via providing some tentative descriptions of experienced affect, then jokingly laughing them off, only to disintegrate when the therapist did not

unquestioningly accept the humorous, minimizing defense but reflected on the mostly painful emotion experienced as something important and valid. Initially, this felt like re-traumatizing the client, despite her verbalized relief that someone could see 'beyond the mask'. Feeling 'seen' and having her feelings acknowledged, contained and validated non-judgmentally, increased her attempts at trying to identify her feelings in therapy though not yet outside, which corresponds with the findings of Garland (1998) and Levy (2004) that validation promotes safety and facilitates gradual opening up.

As feelings could be identified with increasing precision by her within the sessions, the less often Silke dissociated. Simultaneously her reports of neurological complaints slowly increased. It appears that as she engaged more intensely and closely with reality (instead of escaping it), she experienced the pains, disappointments and dilemmas of existence as well as her memories and flashbacks more intensely and communicated this via physical / neurological complaints. This may indicate short-term unconscious escape from the overwhelming affective into the physical realm or inability to articulate unclear emotions, and is concurrent with Herman's (1992) conceptualization of physical complaints as expression of the *unmeantionable* for which words have not yet been found, and which would become redundant when emotional pain can be articulated verbally.

Due to a severe lack of self-belief and confidence, the need for mirroring and confirmation of her as yet mostly hidden abilities was of utmost importance during the safety stage and may have served to buoy her sense of self that had been drowning in the whirlpool. The extremely strong need for dependence due to severe lack of nurturing also led to a strong idealization of benevolent others, such as the therapist, which is not unusual and constitutes the "dependent trust" (Okun, 1990, p.68) essential for the attachment self-psychology deems necessary for re-living developmental deficits in a re-parenting process in therapy (Kohut & Wolf, 1978). In the case of this client this could fortunately be maintained long enough for her to acquire a relatively vital and functioning self with sufficient coherence to cope with miss-attunements, disappointments, and anger which occurred more pronounced in the second year of treatment once safety had been established and she may have felt less likely to be abandoned, and had gathered sufficient self- esteem to more frequently listen to and

trust her own organismic responses (Rogers, 1980) rather than automatically behaving in a manner designed to not upset an idealized perceived authority or parent figure.

Yet throughout this stage, and recurrently throughout treatment, the sabotaging of care and self-created abandonment also continued. Initially this occurred via withdrawal, via refusal to pay attention to self-care, indiscriminate sexual encounters ending in rejection, drinking bouts, and mostly via strong active and passive suicidality.

It is essential to note that Silke's journey to herself proceeded not along a steady yet slow continuum of forward movement with a few breakdowns, but can better be described as a sine curve with high amplitude and rapid cycling. This process did not steady in later stages of therapy but rather appeared to become more intense, yet with increasingly improved ability to maintain gains from the previous productive phase when moving though a (often very severe) downward curve into the next phase of deepening insight and improved integration. This can be linked to the Okun's (1990) description of the natural process of alternating "periods of movement and periods of stagnation" in therapy (p. 64).

5.1.2 Remembrance and Mourning

A gradual shift into the second phase coincided with an increase of sessions to twice weekly, which increased regular availability of the therapist and resulted more predictable and regular behaviour in Silke. A relative normalization had taken place in the therapeutic relationship, which was illustrated by a shift from safety to content.

The supportive holding environment (Holmes, 1995), which Rogers (1980) refers to a positive psychological climate, continued to be the main aspect of intervention, allowing for a more frequent identification of affect and its relation to current events, at times even affect related to traumatic memories, with only the latter being followed by emotional regression or numbing (sedatives), after feeble but increasing attempts at utilizing other, more constructive coping mechanisms or delaying gratification, such as drinking only one or two sleeping pills instead of the whole packet and reluctantly handing in the remainder to the therapist or at the Crisis Centre. This reflected a new level of

competence and confidence, demonstrating the belief that she would find methods to 'cope somehow' once she had handed in the pills.

When no judgment was forthcoming from the therapist, besides wondering if sleeping pills were really the *only* solution, Silke felt less pressurized to pretend to be "good", and started discussing her needs and fears underlying the craving for sedatives and her lack of self-care (starving, self-mutilation via tearing off toe nails). She started to tentatively explore her need to passively rebel against and withdraw from her parents via interminably extended studies and escape into oblivion by way of sleep and sedative use.

This was by no means a linear process and unfolded similarly to a dance of five steps forward, four steps back. Yet once Silke tentatively initiated exploration of her past and family dynamics, she indicated thus that her self had grown at least partially robust enough to withstand the strains of such exploration, if handled in a gradual and cautious manner. It also indicated that basic trust had been established, if only temporarily, and that re-visiting of the past was now possible.

Silke now arrived for sessions with more selective events she wished to relate, comment on, and ask perspective or reassurance on. As her narrative of current events and 'problem situations' became more focused, her narrative of the past became thicker, though it was presented in disjointed vignettes rather than as a continuous narrative, which was an accurate representation of her increasing yet still incomplete self-coherence, as can be expected during the healing process according to Herman (1992) and Kohut and Wolf (1978). Past events could increasingly be experienced with corresponding affect, which temporarily increased the periods of emotional regression, yet the quality of the childlike breakdown acquired a quality of grieving and mourning rather than unfocused emotional distress and fragmentation. Occasionally, tentative connections between past and present were suggested by the therapist, which were initially perceived as a kind of 'mind-reading' by Silke, which she found fascinating. After some psycho-education on how the past can influence the present she found great relief in trying to 'puzzle' together her life narrative, starting to believe that perhaps she was not 'mad' as she had feared.

Once cautious exploration and interpretation were possible and bearable, extremely sensitive topics such as nightmares, family dynamics, and the sexual abuse of the past could be re-looked rather than re-lived piece by piece. Her nightmares still frightened her but had acquired a more distinctly narrative quality, often including an alive and a dead girl meeting or changing into one-another, with threatening male figures in the vague shady background in deserted empty spaces. Sadness, fear, and despair rather than plain horror were the main affects she related with regards to such dreams. One might hypothesize that her self had acquired more coherence, a kind of 'body' instead of disconnected pieces representing her fractured self (Kohut, 1984), or that she was intermittedly reconnecting with her true organismic self (Rogers, 1980), while her psyche was concurrently dealing with grief overload, the sadness and despair of which had been repressed for a long time. This intense engagement with emotions she had so long been unable to feel for fear of being overwhelmed by them and unable to manage them, led to repeated shifts between the will to live and the letting go that goes with death, which is not unusual at such life-defining junctures (Yalom, 1980).

This struggle occurred externally in an ever more intense manner, frequently recurring until termination. The grief of facing her losses, in terms of family members as well as a childhood, sexual innocence, trust, and playfulness proved to be almost overwhelming, especially when defenses such as dissociation and pills were not utilized.

A significant shift took place, when she resisted the temptation to attempt suicide with 150 tranquilizers incorrectly delivered to her house in the eight's month of therapy. She alerted the therapist telephonically, stated she would be able to persevere until morning and then hand in the pills. The therapist expressed concern but trusted Silke's recent improvements in self-management and judgment, treating her like the adult she was trying to become, and agreed. Silke handed in all 150 pills the next morning and stated that she had spent the whole night thinking if it was worth living and decided "I want to live". This was a turning point in therapy and Silke subsequently disclosed that she found it effective and helpful re-enacting therapy sessions or imagined therapy sessions mentally when faced with difficult personal decisions and that it helped her to make a decision she could live with. This seems to indicate a significant step towards the successful internalization of selected aspects of the therapist as a mirroring and idealized self-object, via transmuting internalization (Kohut & Wolf, 1978) or alternatively

as reconnection with her authentic self which she now conversed with and started to trust again (Mearns & Thorne, 1988). This was possible because the empathic breaks were mostly manageable, because extreme caution had been exercised regarding consistency in setting and regularity of sessions, as well as limiting comments to reflections rather than interpretations. However, on many occasions this may have made the therapist appear like an uncaring bystander (no 'active' help) or a withholding parent (refusing to support acquisition of sleeping pills), which created acting out and the realization that the therapist was less all-attuned and ever-empathic than she would have wished, indicating the therapist was also human. This shift indicated a movement towards twinship (Kohut & Wolf, 1978) and mutuality, and more equal participation in the therapeutic relationship with less reluctance to voice own opinions, emotions, and ideas. Naturally, there were various occasions in each session where attunement was imperfect, many of which the therapist may not have been aware of.

During this difficult and demanding time, safety issues and testing of the therapist and strength of the therapeutic relationship continued and led to regular borderline-type splitting (Herman, 1992, 1999) with passive aggression against the 'bad' therapist for seeming to cause all this pain and not providing a quick fix, being acted out in frequent, later carefully narrated, consultations with the 'good' psychiatrist who faithfully prescribed tranquilizers and other medication as requested and may so have fulfilled her need for an omnipotent yet authoritarian father figure who 'took over' and provided her with the external advice and direction while she feared to look for and accept her own direction from her authentic self that was emerging stronger yet might have been perceived by her as still very unfamiliar and uncoordinated and therefore untrustworthy. This process is explored in detail in Mearns and Thorne (1988) and well as Rogers (1980).

While the grief and sadness being experienced as painful and needing numbing to an at times suicidal extent, the anger she felt at neglect and mistreatment in the past as well as the present, started to be expressed more openly. On many occasions her focus remained more strongly in the present, including the therapeutic relationship but also daily life, which from a person-centered perspective could be summarized as a movement from the there and then to the here and now (Möller, 1995). She now attended classes more regularly, faced professors to request additional exams, stating

that she had a right to do so, and after much deliberation and discussion made her needs known more clearly to her boyfriend and insisted on not being patronized and neglected. The relationship did not last. Silke discontinued it when she felt that it was going nowhere. Despite of her emotional anguish at actively ending the relationship, this may be seen as another indicator of her increasing confidence in her views, her true self, her perceptions and reality check, as well as confidence in the validity of her needs and having them met. The step signified a shift towards autonomy (Erikson, 1968) and an increase self-worth (Rogers, 1980), since she did neither go back, find another relationship just to be attached to 'somebody', nor significantly romanticize the relationship retrospectively (See also Section 5.2). Authentic identity formation in a therapeutic environment of object constancy was taking place and resembled that process of passing through emotional adolescence (Erikson, 1968), having internalized a sense of worth and self-appreciation.

From this stage onwards, dissociation and sleeping spells had ceased to be the coping mechanisms of choice. Neurological complaints dominated, which were characterized by both stress induced somatic symptoms as well as elements reminiscent of paranoia and de-realization which may have been remnants of the previously so prevalent dissociation. She reported that she felt people were watching her through pin holes in the ceiling, that she heard noises, and that "dinge beweeg so vinnig and dan weer so stadig en dit maak nie sin nie". Neurological examinations as well as two hospitalizations in this regard led to no findings and Silke concluded that it may be the 'stress' causing all these symptoms. After weeks and months of careful self-observation and discussion she felt convinced that stress, especially emotional stress, was causing or exaggerating the symptoms, and started to feel more confident in coping with them, perceiving them to be of a temporary nature. Her discovery of this connection strengthened her belief in her ability to cope with difficult circumstances and led to reduced avoidance when facing stressors, such as exams or her parents, who she felt were undermining and infantilizing her but whose demands she found it difficult to resist. Every time before returning home to her parents' house for the holidays she started getting tense and nervous weeks before, indicating a fear of "being brainwashed and negatively re-educated" by her parents. This she found was only avoidable if she could manage to hold on to her recent gains in self development and autonomy in creative ways. A transitional object (Winnicott, 1965, in Okun, 1990) in form of a diary was

provided to enable Silke to record her individual mental self-therapy sessions she had found so helpful in the past.

The gradual transition to the next phase coincided approximately with the return from her holiday, with gains rather than losses in capacity, competence and especially insight, accompanied by an expanded need for nurturing and affirmation, while continuing with her often frightening journey.

5.1.3 Reconnection

This phase was characterized by an initial stability and progress that was deceptive. Silke returned from the Christmas holidays at home, reporting she had survived the festive season “deur mentally op my eie te bly … self beskermend op my eie planeet … en my eie reality check toe te pas”. This comment seems to indicate reconnection with her re-vitalized (Kohut & Wolf, 1978) or authentic self (Rogers, 1980) and vastly improved self-esteem, which had strengthened enough to be available to her during extended periods without therapy. She appeared calm and full of energy, with appropriate affect, the ability to verbalize rather than internalize anger, and an increase in self-soothing and self-care skills. Her perception of external reality as well as of her own limitations was more accurate than ever before. She was afraid of outrunning herself and burning out if not reminded to slow down occasionally. She also worried “dit gaan te goed met my”, a feeling that she found most unmanageable and unfamiliar and that had previously always led to a self-induced crisis to achieve a more comfortable affective level, corresponding better with her old self-concept of being depressed, unwell and incompetent.

Yet overall, it appears that an occasional therapy-respite period led to a consolidation of therapeutic gains in this client. This proved to be the case after each subsequent therapy break.

The next ten months were characterized by the most rapid and intense roller coaster process imaginable. Silke herself now initiated and successfully employed exploration and interpretation with regards to current life situation as well as the past, using the therapist for reassurance and perspective, and to journey with her in finding and giving

meaning to her distress (Mearns & Thorne, 1988; Pearlman, 1996). She now often arrived having identified a problem or memory that upset her, having contemplated possible solutions as well as connection of current affective patterns to past events and experiences.

Silke now actively interpreted her dreams, which mirrored life challenges rather than the plain horror and death of prior nightmares, family dynamics, and also her own role in maintaining or upsetting them. The therapist served as container for Silke's anxiety and attempted to caution her not to overextend herself with a part-time job as well as studying full time for a teaching diploma. During this phase the process was a tightrope walk to establish an effective balance between sufficient support and maintenance (characterized by slowing down) and to enable the client to proceed, but not at such a pace that prior growth may be jeopardized by a large-scale breakdown as both Holmes (1995) and Herman (1992) caution.

The crises indeed started following the fast-tracked, insightful sessions on a regular predictable schedule, seemingly representing a tension and anxiety release from the intense emotional work conducted in the twice weekly sessions. During these crises many previously mastered unhealthy defenses and coping strategies re-appeared. Sedative and anxiolytic consumption increased but were titrated by Silke to allow for class attendance and daily functioning. Suicidality increased in concordance with the intensity of the previous week's sessions, but could now be discussed openly.

This intense imbalance and 'rollercoaster ride' in therapy is well conceptualized and succinctly summarized by Mearns and Thorne (1988) from a person-centered, perspective: "*all* the aspects of the therapeutic process are important: in the longer term, dramatic 'discoveries' are useful only in so far as the client can integrate them and integration often takes longer than discovery" (p. 136). It appears that Silke made discoveries quicker than she could integrate them, which led to the intense ups and downs, with the downs serving for re-grouping and integration after a crisis had been provoked post-discovery to 'justify' time-out.

Sensitive and anxiety-inducing topics such as future plans, issues regarding sexuality and body image, as well as intimacy and desire for a relationship were now opened up

by Silke, yet one topic she felt unable to deal with was the impending termination of therapy at the end of the year due to both therapist and Silke herself moving away. Attempts by the therapist to address this issue led to great anxiety, a return of helplessness as well as outright aggression in Silke. After one of these discussions, four months before then end of therapy, she arrived with a packet of sleeping pills, challenged the therapist to prevent her from taking them and when no forceful 'parental' intervention was forthcoming, but discussion and negotiation were initiated with regards to termination of therapy at the end of the year (not the pills), she engaged with the issue for the first time, but still, in a gesture of defiance, drank all the pills in the parking lot after the session "om te wys ek is sleg", and possibly to show that she *really* needed therapy and to prevent 'abandonment' by the therapist (via fewer sessions or termination), which she might have felt to be the consequence of getting better.

This pattern of trying to avoid imagined or real abandonment is not unusual in clients with borderline traits, which are considered common in survivors of complex trauma (Herman, 1992, 1999), yet they are very distressing to both client and therapist. However, this episode set the direction for Silke taking more personal responsibility for her medication consumption. After an initial upsurge of obtaining and consuming sedatives, she started making fewer requests for pills from the psychiatrist, then cancelled psychiatry appointments, reduced other medication and finally decided on homeopathic drops for sleep, which seemed to serve as a placebo and were discontinued when she felt less stressed and her sleeping patterns had taken on a more regular pattern. She described this shift as "die pille is nou minder my baas", which highlights that the craving and need for oblivion had not suddenly evaporated but had been temporarily managed and controlled. This does not imply a clear prediction for a sustained sedative free future, particularly when under stress, but supports Herman's (1992) argument to understand 'co-morbidities' such as substance abuse as integral symptoms of complex trauma and to address them concurrently to therapeutically addressing trauma effects, rather than treating sequentially and requiring a client to be substance-free before commencement of psychotherapy.

Termination and future planning became the focal issues of the sessions, which continued to be characterized by significant increases in insight, including the here-and-now, with interspersed severe crises including self-requested hospitalization, from which

however she seemed to recover relatively quickly and without losing much (if any) of the gains of her previous growth process.

According to Terr (1999), foreshortened future is one of the prominent symptoms of traumatized individuals such as Silke, which was illustrated by her discomfort regarding future planning. She never contemplated having a future in the first place, but as her feelings of competence, agency, and autonomy strengthened, she cautiously attempted to explore a possible future; first within the confines mapped out by her parents' wishes and later increasingly according to her own wishes. She commented as follows:

> "ek het nooit gedink ek gaan ouer as 22 word nie … nou is ek 24 en het toekoms drome en sien myself op 42"

Yet, the future comes at a price, the price of realizing and accepting that family dynamics will have to permanently change because she chose to change herself: "ek voel skuldig om groot te word … my ma hulle wil dit nie hê nie". To understand this and yet to carry on, indicates a fairly stabilized self that acts autonomously, even if disapproval from significant, highly valued and greatly guilt-inducing others is to be expected and in fact is forthcoming, such as non-attendance at her graduation.

In one of her last sessions she stated that:

> "nou dink ek dis fabulous dit het alles gecrumble … nou sien ek ook my swakhede en is minder rigid … en nou verstaan ek daar is lewe en suksess na failures… ek is nie spyt dat dit my lank gevat het om myself agter mekaar te kry nie … nou aanvaar ek die foute in myself en in ander en judge vir ander en myself minder … ek besef nou om 'n slegte ding te doen beteken nie jy is 'n slegte mens nie … maar dis soms moeilik om so te dink … ook oor myself … maar dit maak 'n mens 'n mens"

This insightful retrospective on her experience of growth was promptly followed by a panic call once she had arrived at her parents' place two weeks later. The availability of the therapist to listen to her anxiety as well as her planned and executed coping strategies appeared to provide the much needed 'touch to base'. Her subsequent

graduation from university which she attended without her parents, served both as a public witnessing of the success of this difficult part of her journey as well as a definitional ceremony (Meyerhoff, 1986) of moving into independent, autonomous, competent adulthood.

It cannot be emphasized strongly enough that the process described and explored above did not and cannot ever proceed in a continuous and unbroken line of coherent progress but may be likened more successfully to a puzzle, which the client (re)assembles with the assistance of the therapist, necessitating much trial and error in the process. The crucial yet often misunderstood need to permit the client to pace her own process appears to be the key to continuous, if sporadic and slow, movement towards greater self-knowledge, integration, vitality and meaning, which is however *not* always mirrored by concurrent ongoing improvements in behavioral manifestations.

5.2 Power: Dependence to Partnership

This section describes and tentatively explores the re-emergence of a feeling of agency and power in Silke throughout the therapeutic process. A gradual shift from utter helplessness and dependence to co-negotiation of the therapeutic relationship and daily life is explicated.

Silke's initial central organizing principles:

- I need to be loved, but people abuse me in relationships, so to get love or care I have to please others and let them do to me what they want.
- I am incompetent and weak and need others to tell me what to do, so that I can be "good" and will be loved.
- One cannot trust people, because they say one thing and mean or do another, and I cannot figure out what is real and what is not.

5.2.1 Safety

It is essential to note that Silke's exposure to the trauma-causative, unsafe environment, such as her family, was still operational during therapy, in the form of daily telephone

conversations with one or both of her parents and visits at home during each and every holiday. The severe neglect and emotional trauma inflicted on her by her primary care-givers led to a strong reluctance to deeper interpersonal engagement with others, including the therapist. This alienation, isolation and estrangement from others is characteristic after psychological trauma during which intense affect has not been contained with the help of protective, available others (Stolorow, 1999). This essentially sums up the family climate throughout Silke's childhood.

Her inability to trust others was accompanied by occasional, indiscriminate, inappropriate sharing with strangers, leading to re-traumatisition via inevitable disappointment and betrayal, which re-enforced the initial avoidance of interpersonal engagement. Her inability to make decisions, much less stand up for them if opposed or when in conflict with 'powerful' significant others' ideas or wishes, characterized her isolated and fear-drenched life. She arrived with an explicit need for containment, dependence, and guidance, combined with strong passive resistance and undermining of possible relationships rather than negotiating to have her needs met.

The misleading appearance of initial stability at the onset of sessions was characterized by factual narrative about current events and sometimes her past, which she provided in an almost robotic, emotionally blunted and dissociated manner. Affect was flat, except during the crying spells, probably due to affect being too overwhelming and unmanageable for her. Regressive episodes would be triggered by experiencing painful affect related to childhood experiences, which could not always be fully suppressed, and by tentative questions by the therapist. Coping strategies were limited almost entirely to self-destructive behaviours such as remaining in bed in sedative-induced sleep for days, avoiding human interaction at all costs, and occasional drinking bouts resulting in unprotected sex with strangers. Self-care skills were initially very underdeveloped, possibly because she had not been exposed to a nurturing primary care giver's caring to internalize and emulate, but also due to the severe level of depression she was suffering. Silke often arrived unwashed, sloppily dressed, not having eaten for a day or more, toe nails half torn off (one of her rituals to combat anxiety), and reporting having slept on the floor with the landlords dog "for company", feeling safer with an animal than human beings.

Due to her initial inability to remain in the present and to manage any intense affect, exploration of personal issues beyond the practical and mundane, was experienced as unbearable and threatening by her and would lead to severe regression. This created a situation where presence and non-judgmental, attentive listening rather than active interpersonal engagement seemed the only viable therapeutic option. This led to unintentional application of supportive therapy (Holmes, 1995; Mearns & Thorne, 1988; Rogers, 1980), focusing on routine, regularity, availability, and constant attentiveness without making demands on the client – essentially a stabilizing rather than an explorative process.

The interpersonal interaction during this initial phase was largely characterized by non-verbal power-negotiations. The therapist felt passive in her ever-present, emotional container role, and Silke utilized mostly passive aggression to indicate her need for being accepted and contained without demands on her. Interestingly, Silke did identify and use ways to exercise power from day one by utilizing the language and cultural differences between her and the therapist. Without verbalizing her strategy (which she may not have been aware of) she ensured that Afrikaans was spoken during the session, which put her at an advantage since it is her first language but the therapist's fourth. This put her at ease and fortuitously put the therapist on her toes, requiring full attention at all times, which prevented listening with only half an ear. Secondly, Silke (much later) stated explicitly that she was excited about the therapist originating from a different culture, hoping that this would result in 'new perspectives'. It appears that she was very resourceful in finding opportunities to connect and engage with others and their subjective worlds (views, cultures, languages etc.) as long as she felt relatively safe and could do so unobtrusively.

The above-mentioned strategy of availability and regularity seemed to greatly help to contain her and to create an increasingly safe and trusting relationship, which she nevertheless kept on testing. Silke was on time for her (often bi-weekly) sessions only about 4 times in the first year and missed a number of sessions, usually after particularly emotional encounters. She later reported: "ek kan nie glo nie dat jy elke keer nog daar was en gewag het vir my … dit was so 'n nuwe, snaakse ding dat iemand dink dat ek is die moeite werd is" and "jy was altyd daar en ek het toe geweet jy gaan daar wees and nie met my raas nie, nie soos my ma wat nooit daar was as ek van skool af gekom het

nie, en wat nou nog altyd met my raas". These statements illustrate that availability, acceptance, and sustained empathic-introspective enquiry (Stolorow & Atwood, 1997) dissolve alienation (Mearns & Thorne, 1988) to an extent, and that consistent unconditional regard from a significant other (for example therapist) assists in bolstering self-esteem and self-acceptance, which in time leads to the ability to treat oneself with the same acceptance and regard (Mearns & Thorne, 1988; Rogers, 1980). The improvement in self-esteem led to Silke occasionally engaging with the therapist on a more active explicitly mutual level, in a pro-active rather than reactive manner.

Empathic listening, empathic attunement (Buirski & Haglund, 2001), and congruence (Mearns & Thorne, 1988) on part of the therapist served both to crate a safe environment as well as modeling affect management and clear, direct communication devoid of the double binds she had been used to since childhood. These aspects of the relationship allowed for idealizing transference (Kohut & Wolf, 1978) as one of the main organizing principles of this stage, enabling her to merge with a source of idealized strength, calmness, and clarity in the person of the therapist, who in reality felt nowhere near that calm and confident.

Silke non-verbally (and later verbally) expressed a craving, even demand, for being nurtured and for being in a healthily dependent, symbiotic relationship with a benevolent other; a sort of benign assistant or significant other (Rogers, 1980) who would assist her in verbalizing and mentalising affect and thoughts in a supportive holding environment (Buirsky & Haglund, 2001; Levy & Lemma, 2004) offering empathy and unconditional positive regard (Rogers, 1980). She initially avoided making any explicit decisions in therapy as well as well as in her daily life. This may have been due to fear of failure (for example making the 'wrong' decision) as well as fear of loss of approval, care and support. Therefore, appointment times, spacing of appointments, choice of focus during sessions, managing her studies, her self-care or her finances were all passively neglected, ignored, or sabotaged. This appears to be a result of the consistent lack of nurturing in childhood as well as a protective resistance to the parents' adult demands on her when she was still a child. It often appeared as if she feared to be an adult participant in relationships out of fear to be either overburdened or to make a 'mistake' and then be abandoned, and therefore she continued to conduct herself in a dependent

child-like role, possibly with the unconscious aim to elicit care and to avoid abandonment.

Yet when structure, direction or control were offered in therapy or daily life, she mostly resisted it in a passive manner, such as not arriving for an extra appointment offered after a session of severe disintegration, or not arriving but rather sleeping through an exam a lecturer had re-scheduled to accommodate her missing the previous one. She frequently approached her psychiatrist, whom she seemed to perceive as a powerful father figure, for sedatives and anxiolytics, which he continued prescribing and she kept drinking all at once, creating more sleeping spells and in a way 'proving' that she could not be helped or controlled – a self fulfilling prophecy? However, her resistance could also be interpreted as a pre-test for later engagement, as a trial and error process of calibrating how much engagement and mutual interaction was bearable for her.

This may point towards some deeply buried internal knowledge of her own power and ability to manage her own life and affect, conceptualized as organismic actualization tendency by Rogers (1980), which however seemed to threatening and unmanageable to acknowledge or exercise. During the first stage of therapy she seemed to respond best to a supportive, non-demanding, non-judgmental holding environment, where she felt accepted in her great need and with her internalized organizing principle of being helpless and incompetent. She needed to be able to move through this stage of dependence and helplessness to develop a healthier, stable, non-threatening base from which to move towards separation, more autonomy and accessing of her own power. It appeared that while she initially viewed all relationships in terms of extremes - such as potentially exploitative, demanding and dangerous - as is common in trauma survivors (Herman, 1992), she had now slowly internalized the foundations of a benign supportive relationship due to having her affect (including self- and other-aggression) accepted in a non-judgmental manner by another human being who both assisted in and modeled tolerating and integrating affect (Stolorow, 1999). The therapist had not crumbled under her helplessness and emotional drain, at least not visibly.

5.2.2 Remembrance and Mourning

This stage was characterized by precarious, sporadic attempts at asserting herself as 'expert' with regards to her expertise regarding her own life-story, where she felt less need for guidance. Additionally, small victories in negotiations with less significant others (for example: car mechanic) lead to more assertiveness and ability to confront 'powerful' and significant others in her narrative of her past (for example: the rapist) as well as occasionally in real life (for example: her mother). This shift proceeded simultaneously with improved insight into double-bind communications in past and present and improved her reality check in relationships, which, however, she was not always able to act upon. She managed to negotiate a romantic relationship and its ending, questioning herself and her "fault" in the breakup, but nevertheless emerging with much of her newly found self-worth intact and her new organizational pattern of her as a fairly competent person entitled to make demands on others, relatively stable. She now displayed the beginnings of a healthy sense of entitlement and started to view herself as someone who had something worthwhile to say and was worth listening to.

This period often felt like a time of "adolescence", with Silke searching for an identity (Erikson, 1968), the base to take a stand, and values on which to build her convictions and patterns for healthy interactions – a rollercoaster between dependency and autonomy needs, between clinging to and angrily rejecting others, friends as well as the therapist.

After approximately 6 months of sessions Silke tentatively started accepting responsibility for the choice of topic in the sessions. She arrived with specific topics in mind that she wished to discuss, but as yet without having explored the problem and possible solutions in any depth. The topics of choice initially remained in the relative safety of her current external life (studies, missed tests and exams, telephonic fights with her parents) rather than childhood trauma or reflections on the sessions and the therapeutic relationship. She started formulating more precisely what she experienced as problems in the present, feeling encouraged by persistently repeated requests to explain in more detail, because "therapists are not mind readers". Towards the end of her time in therapy she reflected that this request for detailed description and engagement with her own problems and issues had made her feel that there was

someone who trusted that she indeed had the ability and knowledge to find and manage her own problems and issues, which corresponds with Rogers' inherent actualization tendency (1980) and highlights the importance of accepting the other fully as a subject or person (Benjamin, 1990), not a 'patient' in need of 'fixing'.

This marked the onset of more sustained cooperation and active engagement from her side rather than passive or reactive interaction. The same applied to the tentative exploration of possible solutions / reactions to the stated problems. Though Silke often insisted "ek het nie 'n idée wat om te doen nie", and explicitly requested advice from the 'therapist-expert', she also increasingly ventured some suggestions on how to approach problems. These were taken seriously despite often being intentionally far-fetched, possibly in an attempt to use humour to defend against having her tentative attempts at using her own power and ideas minimized or discounted.

A precarious balance developed, with Silke venturing to gradually, slowly and erratically try out and test her ability to take control over her life and the relationships with others. Initially this occurred only in the safety of therapy sessions where she reported feeling more secure and protected than 'out there', particularly with regards to her parents.

Her internal organizing principles seemed to slowly shift from perceiving herself as useless and incompetent to acquiring a sense of selfhood and exercising some control over her life, even though being aware that this did not extend to all aspects of her being.

After eight months, Silke was able to face a Professor whom she greatly feared and whose exams she had 'missed' three years in a row, to ask for a repeat exam. At the same time she also started sharing self-initiated ways of combating her isolation, paralyzing inertia and difficulty in relating to people. She started sharing journal entries and used written narratives to order her thoughts and to brainstorm solutions to problems, and used breathing and relaxation exercises to successfully combat anxiety. These strategies were chosen by her and reported with much cautious pride and anxious confidence. The relief experienced from such exercises, especially with regards to tension and anxiety, is well documented by van der Kolk (1996, 2007). The journaling, despite being very erratic and disjointed, enabled her to start focusing her thoughts and

to contribute more constructively to sessions. It assisted her in telling and clarifying her own life-story and to more often delve into traumatic childhood issues without totally disintegrating. Self-talk via journaling and 'mind-talk' as well as talking aloud to herself at home seemed to be precursors to active verbal interaction in therapy and real life but may also have been an internalizing process as well as reconnection with her authentic self (Rogers, 1980).

Silke seemed to develop more tolerance for affect connected to childhood experiences and occasionally was able to make tentative connections between the past and the here and now, such as "my ma het my altyd van al haar probleme vertel … all die aaklige goed … ek wou dit nie weet nie … dit was so erg … ek sou nie haar ma wou wees nie … sy doen dit nou nog … en Lietjie (her friend) doen dit ook en ek haat dit". This seems to partially explain her reluctance to engage interpersonally – a passive refusal to be swamped by draining, inappropriately demanding and damaging relationships, having resulted in an avoidance of *all* relationships.

These connections between past and present, however, were reserved for situations and dynamics in the outside world, while she resisted any reflections on the therapeutic situation. This may be due to her need to retain the feeling or fantasy of a perfectly safe space, with a benevolent other, a relationship she wished to keep separate from and uncontaminated by painful current and prior relationships. This may be conceptualised as her needing *extensive* and *uninterrupted* time to access and re-live her mirroring and idealization needs fully in the therapeutic relationship due to the severe lack of mirroring, acceptance, nurturing as well as a concurrent grave deficiency with regards to adults who could have been suitable for idealization and merger regarding strength and soothing in her childhood. Kohut and Wolf (1978) argue that rather than hurry this process along, the therapist should patiently accept the unfolding of narcissistic needs and joyfully respond to the client's expressed childhood grandiosity which may be expressed as wanting to be special, or wanting the idealized object for herself to merge with and become part of it.

Ambivalence was experienced as unbearable and therefore avoided. She found anger and frustration with significant others difficult to express, this included the therapeutic

relationship, and if she ventured to do so even mildly she expressed immediate severe guilt and missed subsequent sessions.

With the increase in confidence, the fear of her own power as well as the frustration of 'all that wasted time' overwhelmed her periodically and she retreated into sleeping spells and sedatives. After approximately a year she was able to extend her more assertive behaviour to events outside of therapy. It reflected also in her taking charge of her studies, including assignments, exams and re-scheduling thereof. It also led to her taking more responsibility for the scheduling and canceling of appointments and an increasingly more significant increase in pride for her own achievements and abilities. During the second year of therapy she drove an hour each way to attend therapy sessions and yet was either on time or negotiated re-scheduling in advance. A distinct move from dependence towards relative autonomy and independence had occurred. Responsibility for logistics and content of sessions became shared responsibility and the intersubjective space of the therapeutic interaction.

Silke was now also able to share more positive aspects of her life and more of her current and previous achievements, possibly due to first having ensured that her helplessness and desperation had been acknowledged, not minimized, and were being safely held, this being an accepted and well-documented process in self-psychology (Okun, 1990).

Alongside the gains, the challenges continued. At various points (until the last few months) she would periodically bring sleeping pills into the session, quietly challenging the therapist to 'parent' her by taking charge and taking the pills away from her, deciding for her what is good for her. When the situation was explored and responsibility was not taken from her, she managed to take charge and resist the temptation to escape reality / life when it would have meant possible annihilation, for example when accidentally 150 sleeping pills were delivered to her instead of her parents during month eight of therapy. However, when she intermittently acquired between 2 and 10 pills, she usually took them in a show of defiance, probably also with the subconscious knowledge that this would not be the end of the road but rather a respite, forcing the therapist to take note and acknowledge that perhaps things were not as good as they seemed. This always appeared to be a sign of requesting reassurance that she was doing 'well enough' and

that maintenance rather than progress was important. This shifting of the locus of control as well as the movement from non-verbalized to more openly negotiated power shifts and power sharing were characteristic of this stage.

The therapeutic process moved from purely supportive to more frequent periods of exploration and reflection. This process always included re-visiting issues on safety and trust as well as maintenance of a very tenuously developing sense of autonomy and personal agency, via both mirroring and yet treating her as a person or subject in her own right rather than a helpless patient (Benjamin, 1990).

5.2.3 Reconnection

During this stage independent action, based on autonomous decisions, not on 'people pleasing' became more and more prevalent and Silke's increasing awareness and exploration of her personal organizing principles led to the possibility of questioning as well as changing them. This was illustrated by the new strategy of negotiation, rather than submission to 'powerful' significant others (parents, therapist, professor). Relationships were perceived and managed on a more equal basis and co-creation of reality and relationships (Stolorow, Orange & Atwood, 1997) rather than acceptance of unpleasant and unwanted reality were explored. On an intimate level, this led to a less dire need for '*any* partner', resulting in the phasing out of toxic friends and indiscriminate sexual encounters.

During the last six to nine months of therapy, Silke managed to develop an increasing amount of new skills and to transfer them into her real-life environment. She chose to substitute homeopathic drops for sedatives and reflected on the helpful placebo effect and sense of control she gained from this action.

Exploration and interpretation became the focus of the sessions and Silke started (and continued at break-neck speed interspersed with many bombed-out respite periods) to unearth and explore traumatic childhood issues, particularly with regards to family dynamics and neglect, and to connect them to current feelings and actions. She now almost exclusively directed session content and started reflecting voluntarily on the here and now of the sessions, actively co-creating and reflecting on the therapeutic

relationship, possibly feeling less need to idealize the therapist, having gained more confidence in her own power to hold and manage her life and emotions. She remarked: “as ek ‘n probleem het en jy is nie daar nie, soos in de vakansie, dan verbeel ek my ek is in ‘n sessie en ek praat dit uit … en ek verbeel my wat jy sou vra of sê … en dan weet ek en dan is dit ok”. And on a previous occasion she summarized it as follows: “ek het nou so ‘n ouer-stem in my kop … dis my persoonike groot mens stem, nie my ouers nie, … en dit praat met my as ek ‘n issue het en dit werk nogal”. This seems to indicate that she has internalized the aspects of the therapist and therapeutic situation (transmuting internalization) that held and helped her emotionally, and that she could access them when in need, and when away from the therapist. This reduced the need for idealizing transference and allows a meeting of more equal partners in therapy, where failings and mis-attunements can be admitted, faced and explored rather than ‘fixed’ to maintain a safe and ‘perfect’ holding situation.

These changes were cautiously extended into the relationship with her parents, to whom she now stood up to more firmly yet respectfully, stating her wishes and preferences more clearly, refusing to be infantilized: “My ma het besluit ek moet volgende jaar Technikon toe gaan en ‘n kursus in prostesis volg omdat ek hierdie jaar nie gaan graad kry nie. Sy sê om nog ‘n jaar hier te bly is geld mors. Toe sê ek vir haar ek stel nie eintlik belang in prostesis nie en het net nog een vak om te slaag en terselfdertyd die onderwysdiploma te verkryg. Dis wat ek wil doen en kan doen en ek gaan ‘n job vind om vir my self te sorg”. She managed to negotiate her last year at university and also got a job as a waitress, a daring and frightening move for someone so isolated and with such difficulties relating to others.

During the last year, her active and passive suicidality diminished significantly, though there were occasional strong flare ups, and she made repeated clear statements of “ek wil nog nie dood gaan nie … nie nou nie” and during the last month of therapy spontaneously “Ek het nooit gedink ek gaan ouer as 22 word nie … nou is ek 24 en het toekoms drome en sien myself op 42”

Future orientation improved with increasing successes at passing exams and holding down part-time jobs as well as a difficult romantic relationship. Finding resources and power inside herself to gain some control over her life helped to re-activate ambitions,

plans and dreams she had thought dead. The search for a coherent personal narrative to make sense of what happened and why continued and was extended into the future. She read Victor Frankl's "Search for Meaning" and felt that it spoke to her strongly, which led to her re-reading it various times, taking comfort in the fact that Frankl could survive and still find meaning and joy, and therefore this could be possible for her too. This illustrates her increasingly more effective search for benign, supportive role models outside therapy as well as ongoing engagement with existential issues. The comparison to a concentration camp existence is not as far fetched as one may believe, since a child's experience of being at her parents' mercy may well be compared to that of captivity (Herman, 1992).

Assertive mental / emotional interaction with rage-inducing elements from the past, such as perpetrators, bystanders, rescuers started taking place in therapy, and anger could now be expressed more openly and sometimes spilled over in verbal rages combined with tears of anger and frustration. She started feeling more comfortable addressing feelings of anger, resentment and annoyance at the therapist with regards to impending termination due to her (Silke's) graduation and planned yet dreaded move to the UK for work. The therapeutic relationship became more frequently a twinship (Kohut & Wolf, 1978), with Silke modeling herself on a benign yet human, and fallible, other. This also increased her tolerance for ambiguity and fluidity that characterizes human interaction (Stolorow, Orange & Atwood, 1997). She now also asked the therapist more questions about herself and how she 'learned to make therapy work', engaging with her as a human being rather than merely utilizing her as a self-object to fulfill her unmet needs.

The open expression of anger seemed to have unlocked the capacity for joy and the return of hope. This was mirrored in the content of her dreams as well as her increasing willingness to try and find meaning in her dreams and life herself instead of avoiding, waiting for, or asking for interpretation. The ability to access and make use of helping relationships and practical assistance improved and she shared more of herself with appropriate non-abusive others. Medication usage was reduced and requests for sedatives from the psychiatrist subsided. She now used the therapeutic space as a reflection space and the therapist as a sounding board and witness of her progress, sometimes for slowing her down and containing her. The relationship had become one

of mutual respect and negotiation of boundaries and content rather than merely a supportive holding embrace.

Towards termination Silke became preoccupied with the appropriateness of retaining a transitional object after termination, such as taking a photograph of the therapist or obtaining her email address. Simultaneously she explored the appropriateness of giving a gift to show her appreciation for the process she found helpful. Both retaining part of the therapist and giving part of herself were considered to be equally important. This may mark a consolidation of her sense of being competent and an equal, who can both give and take and most importantly *has something worthwhile to give*.

Silke had developed a sense of agency and organizing principle of herself as a very resourceful and mostly competent person who feared failure and rejection less and co-created her own life and shared this reality more actively. The therapeutic relationship had moved from a power imbalance with most of the power on side of the therapist to a relationship of shared power, in which Silke fully participated, made her needs and demands known and could bear and express intense affect and ambivalent feelings.

It is noteworthy that her diaries reveal her own personally experienced process of empowerment to always be a few steps ahead of what was exposed during therapy, possibly due to extreme caution with regards to exposing too much capability and so forfeiting care and containment, or concurrently due to fear of trying but failing to use her own power. This illustrates that she was *never without* power but rather struggled to access it and to utilize it consciously and constructively.

5.3 Transference and Countertransference: Anxiety Ping Pong

This section serves to explore transference and countertransference dynamics in the therapeutic relationship. This process is also termed co-transference in intersubjective theory (Buirski & Haglund, 2001), emphasizing the mutuality and interrelatedness of the process. Rogers (1957) describes this process as I – Thou relationship, however, focusing on the content and effects of immediate interaction rather than past influential factors.

Transference and countertransference are an essential aspect of the therapeutic relationship, in fact of any relationship, and may be utilized consciously or, if unacknowledged, present as inexplicable obstacles.

Transference and countertransference may be an intended, expected and utilized element in diagnosis and therapy, though it may not necessarily be 'brought on' as in psychoanalysis. In the treatment of this client, mirroring, idealizing, and twinship transference (Kohut & Wolf, 1978) were noted and utilized (See 5.1 for practical application).

However, besides the constructively utilizable aspects of transference, there were also those aspects of the relationship that caused empathic strain (Wilson & Lindy, 1994) via intense and disturbing transference reactions which had a "life-or-death quality unparalleled in ordinary therapeutic experience" (Herman, 1992, p. 136). These latter aspects are explored in this section with focus on how they both hindered and aided recovery.

5.3.1 Safety

Silke's traumatic experiences commenced before she would have been able to successfully conceptualize and verbalize them, due to her age, developmental stage, as well as lack of comparative opportunities permitting recognition of the situation as traumatic. Therefore, therapy was initially characterized by non-verbal re-enactment of trauma constellations rather than verbal narrative. Her excessive dependence, limited impulse control, inability to actively fantasize, explore options or to plan, illustrate that most developmental milestones were either not achieved, or (perhaps in addition) the regression was severe (McFarlane, 1996).

In her re-enactments of the trauma she seemed to unconsciously attempt to push the therapist into an uncaring, demanding, cruel, sadistic parent role, so as to match her behavioural defense of meek, helpless, passive-aggressive child (See also section 5.1). Her initial enthusiasm for therapy was matched by her consistent sabotaging of participation and 'progress' as well as any suggestion that could be construed as a demand on her. The therapist felt as if Silke was waiting for, or in fact creating, a

situation where the therapist would reject her, reprimand her for her failure to perform, and then abandon her. Her continual late coming, missing of sessions and passive resistance to any external suggestion, were confusing and anxiety provoking for the therapist, who was attempting to assist and support her rather than find fault. Only later, once a more detailed history emerged, the case had been taken to supervision with much desperation, and more knowledge of psychodynamic theory had been acquired, did the understanding emerge that Silke re-enacted the defense she had used against parental neglect and inappropriate demands; that is passive aggressive resistance. Simultaneously, she expected the therapist to abandon and neglect her for non-performance, then seemed unable to bear the tension when this did not happen, and as a tension-reduction strategy she either disintegrated and regressed completely or alternatively abandoned therapy herself when she felt she should have been abandoned (for example when she could not handle events in real life or emotions in therapy).

Despite her fragmentation, Silke displayed what Herman (1992) calls an "uncanny attunement" to unconscious and non-verbal communication, and a well developed ability to 'read' people, including therapists, the situation, and inherent vulnerabilities and to 'test' the authenticity and safety of the therapist and the therapeutic relationship over and over. In her diary she questions if this therapist will last, since "this one she looks like she cares but can she handle it". So she continued testing if the therapist would be 'good enough' and could be trusted to last, a common but strenuous process particularly with regards to low-trust, therapy-wise clients (Mearns & Thorne, 1988).

This early part of therapy in particular (but essentially the whole therapeutic experience) was saturated with an intense anxiety transfer from client to therapist, which paralleled and to some extent was a result of the above transference. Much of the anxiety, helplessness and overwhelmedness Silke would have experienced as a child victim was now transferred to the overwhelmed therapist, who felt numbed by the complex, disjointed and sometimes horrific narrative presented in a dissociated manner. This was exacerbated by the therapist's very real recognition of her inexperience in treating such a case as well as anxiety to 'perform' as a therapist.

Initially, this led to a kind of emotional paralysis in the therapist, which may have reflected the client's dissociation, but also had aspects of what Wilson, Lindy and

Raphael (1984) term Type I countertransference, characterized by empathic withdrawal and repression to protect against fully engaging with the trauma but also to defend against vicarious traumatization. This manifested in the therapist 'doing nothing', ceasing to make suggestions or applying any 'curative techniques' but rather just maintaining a benevolent and regular presence with occasional reflections on the client's narrative.

This 'doing nothing' and the shared helplessness with the client increased the feeling of being de-skilled and incompetent, and put the therapist at risk to succumb to hopelessness and blindness to the client's well hidden but existent strengths. This was averted only due to the therapist's inherent humanist worldview which places great emphasis on hope against all odds, as well as ongoing peer and professional supervision, permitting de-briefing and in-depth discussion of the case, diffusing some of the strain and anxiety.

As Silke's attendance stabilized and a therapeutic alliance began to form in earnest, the therapist felt that she was often idealized as the 'good parent' who would have the answers, fix things, and make bad things undone. This is an expectable development which may carry many benefits for the client (Kohut & Wolf, 1978; see also 5.1), but led to emergence of type II countertransference (Wilson et al., 1994) in the therapist, evoking rescue fantasies and potential over-involvement, with the client constantly on her mind, and a strong preoccupation with this particular case.

Many of the observations explored here were not so clearly accessible to the therapist at the time, but crystalised only during concurrent and later literature study. Transference issues were not discussed with the client during this stage, owing to the therapist's lack of clarity regarding this process as well as the client's fragmentation, which would have made it unwise to progress to such exploratory work at this stage even if the therapist had been fully aware of the transference processes (Holmes, 1995). During this phase the modus operandi was attention to awareness of countertransference, then a tentative exploration of the triggering transference as well as personal issues, all conducted in supervision, not with the client.

5.3.2 Remembrance and Mourning

After some progress in the therapeutic process and a quite solid relationship, which nevertheless was frequently and persistently tested by the client, Type II countertransference, characterized by enmeshment in form of over-commitment and rescuer-fantasies remained a substantial risk. Silke's sporadic progress and even small successes lead to a wish to push her to continue on this path and to conduct herself more and more pro-actively and productively, without allowing for enough time to rest and 're-group'. The difficulty to insist on maintenance rather than progress, to not be demanding, and to continue with empathic enquiry (Kohut, 1984) rather than take a prescriptive or punitive parent role was exacerbated by Silke's own new-found excitement in her progress, particularly after solid successes like passing exams. Any pressure, or even the unspoken assumption of it (conveyed by the therapist or just assumed by Silke) led to break down, enforced rest-periods, and regressive coping mechanisms, i.e. sedative abuse, and kept the therapist in constant suspense regarding her well-being as well as creating an expectation that the therapist would find some magic solution to help 'fix' this new or recurrent problem.

This never-ending roller coaster, which even intensified during the final phase, created and maintained a sense of panic and constant suspense in the therapist who was often bewildered and confused by the Silke's rapid fluctuations in affect, perception and self-cohesion. The need for supervision and peer supervision remained high, and the therapist found herself constantly arguing her client's case in an over-protective way, reminiscent of advocacy rather than therapy.

Particularly during this time, it was difficult to suppress the urge to collaborate with the client in her unconscious attempts at the splitting of her help-system, that is succumbing to blaming and attacking her psychiatrist who kept prescribing the sedatives, which the therapist felt she should discontinue, and who was not amenable to cooperate in this regard. It was equally difficult to resist verbally 'attacking' her parents, or her description of her parents, in therapy but rather to role model how to bear ambivalence without blame or retaliation, for example withdrawal as response to her choosing to cooperate with what the therapist perceived as destructive forces in parents and psychiatrist. Part of this tension may have been the then unconscious specialness-fantasy of the therapist,

who felt that she had assisted Silke in progressing while others previously had not, and that therefore she felt they should cease to 'interfere'. This shows an embarrassing lack of credit given to previous efforts, which may have paved the way for later progress though not visible at the time.

Regular set-backs, however, remained a common feature and continued to be hugely anxiety-inducing in both client and therapist, often evoking a feeling of ultimate defeat in the client, which was difficult for the therapist to not assimilate and introject. During this phase of treatment the therapist gained a better awareness of transference and countertransference and though anxiety did not significantly lessen, it could be better understood and contained, transference issues could be identified and examined more easily and were discussed in great detail with a new supervisor, creating more insight.

Tentative explorations of transference issues were attempted in therapy but not declared as such. Countertransference was used as an indicative tool to access perceptual and behavioural patterns possibly related to or caused by earlier trauma. Frequently, when a strong emotion such as exasperation or desire to protect, or rather over-protect was aroused in the therapist, this would be utilized via commenting if Silke sometimes felt she was being protected unnecessarily and if she could describe these situations in past or present. This would then give both client and therapist a better reality check on what she felt she could handle herself, and where she had in fact shown strength and competence but it had gone unnoticed and so led back to a projected rather than authentic helplessness. An example in case is her parent's emphatic insistence that she move overseas to work after completion of her degree to 'make real money and pay back her studies'. Silke expressed great fear of moving to an unknown place, losing therapeutic support and not being able to find her way around an unfamiliar city. The therapist felt a strong urge to protect her and support her feelings of helplessness and wanting to stay put, but nevertheless asked if she had felt like this before or had experienced a similar situation before. Silke revealed that she had in fact been overseas trice before at a much younger age and also without parental support and had in fact fared well despite her prior anxiety. This excavation of previous strength and competence helped re-affirm Silke's belief in herself and created a situation where she could safely voice some excitement about leaving to lead her own life. The therapist wondered if her need for helplessness and staying put was partly due to habitual

helplessness, partly to satisfy her parents who preferred seeing her as a helpless child despite the demands they made on her, and partly to not hurt the feelings of the therapist whom she would then leave behind not needing her that much any longer (and whom she might have expected to want to hold her back by feeding into her feelings of anxiety and incompetence, similarly to her parents in the past).

At many other times the awareness of countertransference simply served as self-monitoring, and as a warning for the therapist to emotionally and mentally take a step back and observe and listen more carefully rather than to act.

5.3.3 Reconnection

During the last phase of therapy, the rollercoaster of hope and excitement on the upside, and despair and frustration on the downside, continued and intensified, evoking strong reactions in both client and therapist. The intensification of affect in the therapeutic relationship, communicated in both transference and countertransference, seemed to be a reflection of the impending termination and the related anxiety regarding to how much therapeutic work or improvement would be possible during the remaining months. Silke appeared to deal with her anxiety by cramming more and more issues into the therapeutic space, missing fewer sessions, insisting on twice weekly sessions until the last week, participating much more actively in exploration and interpretation of traumatic past events and connecting them to present affect and behaviour patterns. With this frantic increase in content, engagement and concomitant affect, plus full time study and a part time job, Silke frequently 'crashed' emotionally, seemingly as a result of too much insight and concurrent affective overload. This created enormous anxiety in her, wondering if after all the progress she was again back at the beginning, and this proved to be contagious for the therapist, who however had by now acquired at least cognitive if not yet affective confidence in the process.

This stage proved to be emotionally extremely draining because its main issue was Silke's life-or-death issue of separation, the unavoidable good bye that could be construed as either rejection and abandonment as in the past or as something new, namely a move into personal autonomy, independence and finally healthy inter-dependence.

The improved cooperation and the increase in autonomy and self-coherence in the client led to a more adult way of working together side by side in the process of 'will it or wont it work out'. Silke now displayed fewer dependency needs (for mirroring and idealizing) but a sharp increase in need for perspective, discussion and affirmation with regards to already thought-through and decided-upon strategies. This coincided with her now initiating discussions and explorations regarding old behavioural and affective patterns and their impact on her current functioning. Initially she limited these explorations to daily events outside therapy, but in the last few months (feeling time pressure?) she increasingly reflected on the interactions in the therapeutic process and relationship, including reflections on 'negative feelings' such as anger, resentment and sadness. She expressed her surprise at being able to do so:

> "dis nogal baie snaaks om oor 'n relationship te praat met die persoon met wie jy die relationship het … soos nou hier by jou …miskien kan ek dit eendag ook met ander mense doen"

> "dis baie goed vir my om hier te huil, maar ook om hier te lag, maar dit voel bietjie weird … die lag is soos om weer te leer loop na die heupoperasie … ek voel asof ek eers weer moet gewoond raak … dis nie so outomaties en vanselfsprekend nie"

Silke had become more aware of current affective, cognitive and behavioural patterns, comparing them to previous patterns, for example with regards to her relationship with her mother or other family dynamics, which opened door for revisiting and in-depth exploration of events that had been dealt with earlier therapy, but always in a more insulated manner. This process of moving from awareness of current patterns to exploration of past patterns seems to mirror the therapists increasing awareness of countertransference and its use as signal to look at and explore triggering transferences as well as own needs that could have caused it.

Termination also raised questions regarding the strength of attachment of the therapist to the client. Possibly to avoid over-involvement, which was a tight rope walk most of the time, the therapist found it difficult to admit to herself (and the client) how much the

relationship and the client meant to her and how greatly this journey had impacted on both parties. It was easier to intellectually acknowledge the jointly walked (crawled?) path of enquiry and cooperation in finding meaning in Silke's life-story, rather than to deal with the strong emotional interpersonal attachment, which felt almost like a boundary violation but yet is so essential for successful treatment (Herman, 1992; Wilson et al., 2001). During the termination period, the therapist often felt like an overprotective, anxious parent trying to contain these feelings, while supporting a young person's entrance into ever more increasing autonomy, independence, and self-sufficiency, termed "empty next" feeling by Whitaker (1989, in Okun,1990, p. 79).

Symbolically, this step was represented by attending her graduation, which the parents were unable to attend (which raised a number of additional issues), and which served as both a witnessing and validation of her success as well as a definitional ceremony (Myerhoff, 1986) signifying a coming-of-age, as she put it.

However, therapist anxiety lessened significantly only after a once-off top-up session one year after termination on the client's request, which according to Mearns & Thorne (1988) is not unusual, during which the Silke conveyed, both verbally and non-verbally, that she had grown and matured greatly during this time and had managed to utilize the strengths she had started to unearth previously. Discussion of transference issues was now possible, and in fact requested. Her focus had shifted to identifying tools and strategies that would assist her to become quicker and more effectively aware of what was happening in her and with her, how to make sense of it and find meaning for it, and how to develop successful strategies to deal with issues not yet resolved. This of course cannot be generalized to apply to all or even the majority of cases.

5.4 Impact on the therapist

There is no doubt that the fragmentation and disjointedness experienced by the therapist throughout the therapeutic process with this client, has found its way into this paper, into the way the case is presented and discussed. This reflects the complexity of the case, of its conceptualization and its treatment, as well as the therapist's reflections on it.

It was not an easy task to pin down and explain the treatment process coherently, and the therapist feels she only partially succeeded in conveying the intense, strenuous journey with the client which constituted the intervention. Due to the inherent and unavoidable movement from one treatment phase into another, both forwards and backwards, in an often non-linear and spiral-like process, many overlaps exist between different phases, including events and dynamics that occurred at such times. More time and distance to this case, as well as therapeutic interventions with similar clients, may lead to a more and more clarity and a better integrated synthesis of approaches used.

Ongoing reflection and intense engagement with the case over years have led to increased knowledge on complex trauma and its treatment, but most importantly have led to and consolidated the realization that clients contribute greatly to therapist-growth.

The therapeutic intervention that brought about change in the client (as discussed above) also led to significant personal and professional development in the therapist. Personal growth encompasses the development and appreciation of increased humility, patience, confidence, and a certain stillness that comes with 'just being' without frantically trying 'to do'. This has been a true milestone for a person generally considered both over-active and activist.

Professional growth included increased knowledge about psychodynamic approaches, which were not an integral component of the curriculum at the time, integration of this newly acquired knowledge with prior knowledge and methods such as person-centered therapy, the (admittedly at times haphazard) application of these theories and methods in therapeutic interventions, and an attempt at creative synthesis of these approaches and methods as outlined in this paper. At the time of the therapeutic intervention with the client, the encounter was steeped in person-centered therapeutic interventions, which was followed by increasing intellectualization of the case, as the therapist kept reflecting on it. Psychodynamic understanding, conceptualization, and interpretation of the case and its dynamics were then applied within a phenomenological research framework and the therapeutic relationship was extracted to be a most salient factor in the healing process.

Summarily, it can be said that therapist and client encountered each other in a genuine, deeply human way, which left traces in both their lives, and that this relationship, rather than the any specific approach or method, was the agent of change in the transformation of both the client's and the therapist's live.

6. Conclusion and implications

The main theme permeating this paper is integration. Integration of diverse theoretical approaches and therapeutic methods, increased integration in both client and therapist, and integration of psychodynamic interpretations of the case study within a phenomenological research framework.

The treatment approach utilized in this case study represents a kind of psychodynamic person-centeredness, combining psychodynamic understanding with the principles and practical applications of person-centered therapy. The common denominator is the emphasis on the therapeutic relationship, and this research accentuated the importance, even necessity, of creating and maintaining this interactive I – thou relationship between the client and the therapist to heal damage to self and relational ability.

The impact of this journey on the therapist was significant and has resulted in much personal growth with regards to reflecting on and questioning the impact of a strongly pro-active or activist stance in therapy and beginning to come to terms with experiencing helplessness as essential and not necessarily detrimental part of life as well as therapy. To have been permitted to accompany a person on such a difficult and inspiring journey from despair to life is a humbling experience that will hopefully benefit future clients.

Safety, trust, patience and a good therapeutic relationship with full therapist commitment are paramount when treating complex trauma. The seemingly "doing nothing", which is initially required of the therapist and may be highly anxiety provoking, is actually the much needed and beneficial "being there" of a significant other, which provides the stability, availability and congruence, which are necessary to stabilize and contain the client, enabling the client to reconnect with her true self and to participate actively in the process of healing and reconnecting with life.

It is important to accept the client's momentum or lack of it in therapy, to abandon concepts of speedy progress or growth and to accept that the healing process will most likely be a relatively long one. Attentive empathic listening and bearing not to know resulted in more 'progress' for the client than charging ahead.

A basically positive outlook on life and humanity, enabling unconditional positive regard, empathic attunement, and an inordinate amount of hope against all odds is essential if one wishes to embark on the treatment of complex trauma. The history and condition of this client is complex and often deeply saddening and does not lend itself to quick or easy solutions or even understanding. The client's expertise in telling, re-telling and determining her journey is therefore paramount, and the therapist experienced that her role is that of a supporter who accompanies the client on her journey rather than a guide who directs her, trusting in the client's own abilities, however difficult or counter-intuitive this may seem.

Due to the growth that has taken place within this client, the question is raised if a more psychodynamic approach combined with person-centered therapeutic methods, may be recommended as a first-line treatment for clients suffering from complex trauma.

Lastly, psychodynamic interpretations of the case study were incorporated within a phenomenological framework of research, which may lead to more in-depth research in dealing with complex trauma.

7. Limitations of Study

The study, being a single case study, does not claim to be representative of complex trauma cases. The therapeutic approach, combining different theoretical and therapeutic approaches, was arrived at in a semi-serendipitous manner and formalized and theoretically grounded *during* and *after* therapeutic intervention, which makes the study difficult to replicate.

The client who participated in the study was an articulate, educated and relatively psychologized young woman from a middle class background, who was familiar with the process of psychotherapy. The approach may be less successful with a person from a

less affluent background, with limited access to education, less ability to verbalize, or culturally not relating well to either psychotherapy and its talk-centered process, which requires an often anxiety inducing extent of self-diclosure. Cultural differences regarding appropriateness and desirability of child-rearing techniques as stipulated by self-psychology and person-centered psychology may also reduce uptake and efficacy of this type of intervention, and so may language barriers.

Furthermore, individual and cultural differences regarding the desirability of individuation as opposed to group cohesion and inter-dependency may conflict with the individualistic, developmental and growth orientation espoused in the theoretical understanding of this type of therapy.

The focus of self-psychology on internal conflicts as well as relatedness to primarily one other individual or few individuals, and humanistic psychology's focus on the individual and its growth, puts them at risk to neglect the socio-cultural context which may be causative of the conditions, the effects of which the therapist tries to address, such as generalized violence and patriarchy in society, poverty, lack of parenting skills and education, as well as stigma and discrimination.

Furthermore, it could be argued that a psychodynamically conceptualised approach requires extensive resources regarding time, finance and motivation from the client, due to its protracted length compared to CBT processes, which tend to be briefer. This study was conducted within the academic environment as part of a free counseling service which may have obscured at least the financial implications such long term therapy would have for a paying client.

Lastly, it needs to be highlighted that this study describes and explores a process of theoretical and procedural integration that is ongoing, open to criticism and change, and by no means a complete new approach or theory. Rather, it is part of the journey of this particular therapist's continuing professional development and of her quest to combine and maximize unique individual strengths and steadily increasing knowledge in a creative way and so to improve her ability to assist clients.

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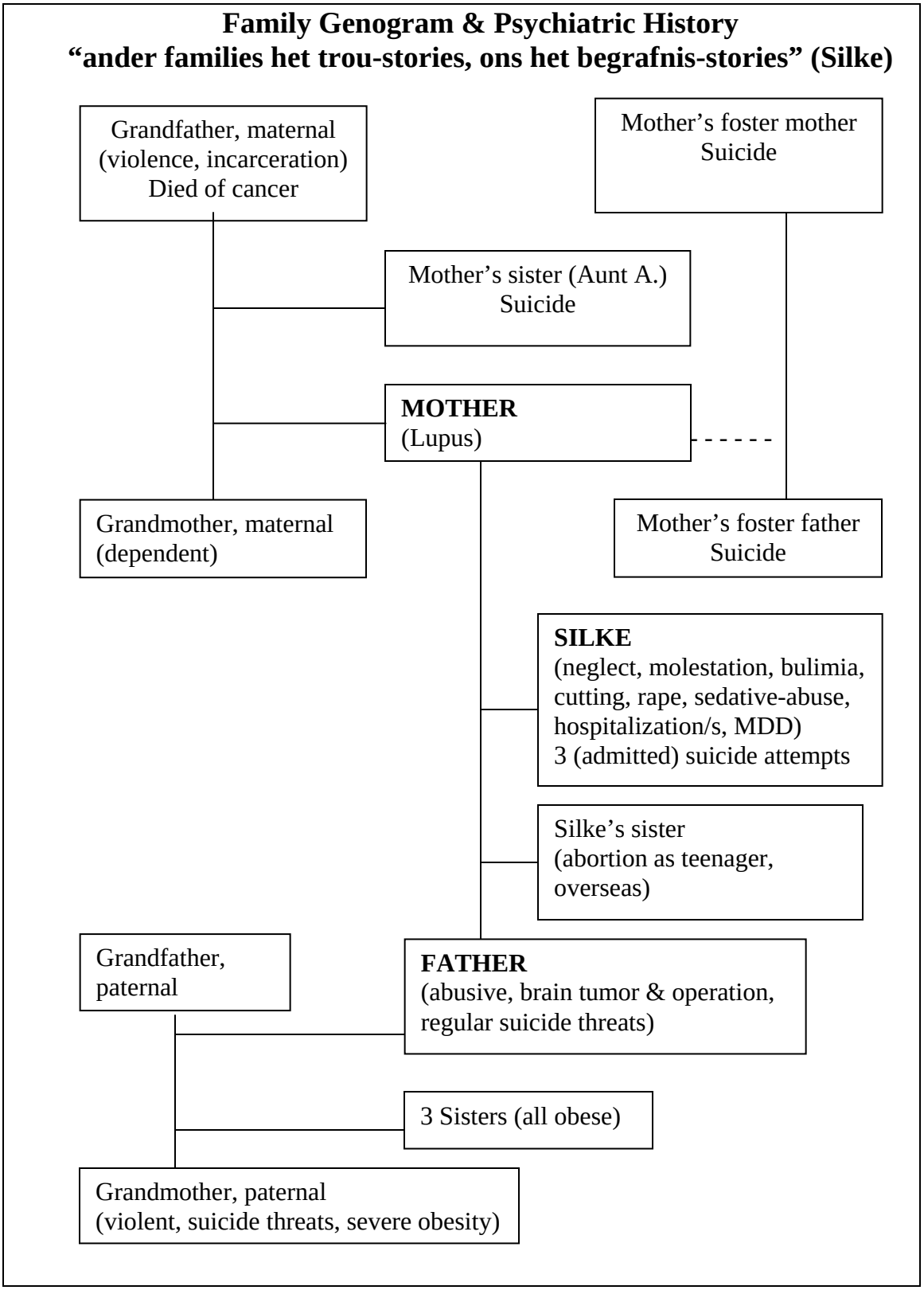
APPENDIX A


Family Genogram & Psychiatric History
"ander families het trou-stories, ons het begrafnis-stories" (Silke)
Grandfather, maternal
(violence, incarceration)
Died of cancer
Mother's foster mother
Suicide
Mother's sister (Aunt A.)
Suicide
MOTHER
(Lupus)
Grandmother, maternal
(dependent)
Mother's foster father
Suicide
SILKE
(neglect, molestation, bulimia, cutting, rape, sedative-abuse, hospitalization/s, MDD)
3 (admitted) suicide attempts
Silke's sister
(abortion as teenager, overseas)
Grandfather, paternal
FATHER
(abusive, brain tumor & operation, regular suicide threats)
3 Sisters (all obese)
Grandmother, paternal
(violent, suicide threats, severe obesity)

APPENDIX B

Personal and Family History

-2 Mother pregnant with Silke's sister M.; Silke's parents get married;

0 Silke is born

Little information and memories regarding infant years
Primary school years; afternoons alone at home, ProNutro-time, sleeping spells

9 Hip operation; in plaster; sexual molestation by mentally disabled young man during holiday, incident known to parents but never reported or followed up

17 Start of bulimia nervosa, feeling permanently fatigued, still performing well at Arts High School

18 Raped by sister's boyfriend (first sexual encounter), reports it to parents, revelation met with abuse by father and attempt to 'keep things in the family' by the mother, no report, first overdose on (father's) sleeping pills, emergency hospitalization, first diagnosis of MDD, Prozac prescribed, Matric exams passed

18-23 Registers at Stellenbosch University,
Mother diagnosed with Lupus
Father diagnosed with brain tumor (operation -> pension)
Prozac continued,
Sedative abuse ("*losing days*" sleeping)
Unclear number of suicide attempts
Frequent use of crisis service,
Individual therapy (2001/2/3),
Failing academically
First long term boyfriend -> break up

21 Aunt A. dies,
Silke hospitalized after seemingly psychotic and / or suicidal episode,
ECT, Efexor replaces Prozac, Topamax and Seroquel added, Ativan as needed

10/03/2004 Call to crisis service -> evaluation -> start of therapy