Into the Darkest Places

Early Relational Trauma and Borderline States of Mind

Marcus West

ROUTLEDGE

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To Liz
who has borne with me through the darkest times

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INTRODUCTION

This book reinstates trauma, and early relational trauma in particular, to what I suggest is its rightful place at the heart of our understanding of psychological distress and analytic thinking. Although it was not my intention when I started writing the book, the book offers an integration of analytic theory, trauma theory, and relational theory, yet represents a critique of each. First, it critically revisions analytic understanding, attitudes, and techniques in the light of a trauma perspective, offering, in particular, a different view of borderline states of mind. Second, it argues that working with the extreme states of mind consequent upon traumatic experience requires an analytic attitude in order to safely and fully address the individual's early traumatic experience as it has come to be embodied and elaborated in their personality and ways of being with others. Third, it provides an understanding of the pressures and dynamics in the analytic relationship which challenges some relational models of analysis, suggesting that the analytic task may precisely require the working through of what feel like inhuman experiences, thereby properly accompanying the patient "into the darkest of places". I have come to realise just how radical and contentious the book is—there is something here to challenge, or offend, most practitioners, depending on their turn of mind.

The central organising concept of the book is a developed and elaborated view of Jung's complex, which is understood to embody both trauma-related internal working models and primitive responses to the trauma (which constitute narcissistic defences). This conceptualisation of the complex thus draws on the insights from trauma theory regarding the primitive, somatic-affective reactions to trauma (and early relational trauma), although the book focuses on the relational outworkings of these experiences as they have come to be embodied and embedded in the individual's personality and as they are met with in the consulting room.

* * *

A recognition of the significance of early traumatic experience has been at the heart of both psychoanalysis and Jungian analysis since their inception. Freud's earliest theory, his seduction theory, was essentially centred on trauma. As well as many other things he also bequeathed us an understanding of fixation points, enactment, and repetition compulsion (much of which was drawn from the work of Pierre Janet, whose work has been largely overlooked until recently). However, in relation to trauma, Freud came to emphasise inner-world fantasy, relating to infantile sexuality and the Oedipus complex, over real-world trauma; later Kleinian thinkers have come to enhance this split further.

Jung's work also began with trauma with his word association experiments, and he developed the concept of the complex, drawing on Janet's conceptualisation of "fixed ideas". Yet his interest also moved away from the trauma itself, shifting instead towards the archetypal, collective layer of the psyche, the collective unconscious as he called it, which is particularly accessible when ego-functioning has been disrupted by trauma, as I shall be explaining (Jung, 1911–1912, para. 631). Whilst Jung stressed the need for integration of the disparate, dissociated elements of the psyche, which is also key to this book, and went on to develop a detailed picture of the intersubjective, mutually influencing relationship between patient and analyst (presaging the insights on the intersubjective field and relational psychoanalysis by many decades), he was not able to follow through his insights into offering a safe and effective way of working with patients with a borderline psychology. Many later Jungian analysts have turned to psychoanalysis for guidance in this area. Michael Fordham, integrating psychoanalytic influences, took Jung's work forward with his conceptualisation of

"defences of the self" (Fordham, 1974), an area which I develop further in this book.

Despite these beginnings rooted in trauma, in reading analytic papers there is almost always a disjunction between the appreciation that "behind this particular syndrome" (whatever that may be) there lies traumatic early relational experience, and a full understanding of how that has affected, and continues to directly influence, the individual. This book aims to address that disjunction.

In the last three decades there have been many ground-breaking contributions from trauma therapists, attachment theorists, intersubjectivists, and relational psychoanalysts, as well as from infant researchers and neuroscientists. Specifically relevant to this book is a growing appreciation of the foundational role of early relational trauma in borderline states of mind, with Herman, Perry, and van der Kolk (1989) proposing that borderline personality disorder significantly overlaps with what Herman has termed complex post-traumatic stress disorder (complex PTSD). Fonagy and colleagues have come to a similar recognition from a psychoanalytic and attachment theory perspective (Fonagy, Steele, H., Moran, Steele, M., & Higgit, 1991; Fonagy, Gergely, Jurist, & Target, 2002; Fonagy, Gergely, & Target, 2008).

I will be outlining and summarising many of these contributions, which give us radical new insights into the traditional difficulties and challenges of analytic work. However, the accommodation between psychoanalysis and trauma work has been at best uneasy and at worst conflicting, with sometimes radically different attitudes and methods being adopted. I believe these conflicts follow from the realities and difficulties of working with states of mind that sometimes feel impossible to bear, for both patient and analyst.

Trauma therapists have been critical of analytic techniques, suggesting that they are too cognitively based, ignore the somatic and affective elements, expose the patient to unbearable and unworkable levels of distress, and are thus inhuman and anti-relational, as well as being unrealistic, ineffective, unhelpful, critical, punitive, and retraumatising. As a consequence they have frequently adopted alternate ways of working, trying to manage the therapy in a certain way, and frequently promoting positively toned ways of relating.

Whilst understandable, I believe these ways of working have limited the recognition and integration of the blackest and most destructive elements of the patient's experience, and their primitive responses to

their traumatic experience. It is precisely the all-too-human "inhuman" aspects of relationship that are traumatic and need addressing. These theorists have not fully recognised the way in which traumatic experience has become embodied and embedded in the individual's character structure and, in particular, the ways in which it becomes manifest in the analytic relationship.

Thus, whilst the re-enactment of early trauma and abuse is always a feature of the analytic relationship, these non-analytic practices can unwittingly fuel re-enactments particularly strongly (or at least an analytic attitude is important in being able to recognise the enactments), sometimes leading to the breakdown of the analysis (Davies & Frawley, 1992a; this book Chapter Eleven). I have found that only when the analyst is prepared to accompany the patient "into the darkest places" whilst maintaining an analytic stance, can the most disturbing, disruptive, and unbearable aspects of the trauma be worked through and integrated, as I will describe below. The attitude of facing the trauma directly is itself a divisive practice and instinctively many practitioners of all denominations balk at it.

Similarly, many analytic practitioners have selectively focused on certain, limited, aspects of the individual's reactions to trauma, frequently their internal reactions, with the link to the original trauma being lost completely. I believe that this has occurred partly due to the patient's clinical presentation, where the powerful affects associated with the trauma disrupt the individual's thinking, containing, and memory-storage functions, so that there is no coherent, autobiographical narrative. At the same time the affective-somatic reactions related to the original trauma become free-floating (dissociated) and attach themselves powerfully to current experience (van der Kolk, 1996a). It is these limited reactions that psychoanalysts have then privileged, divorcing them from the larger picture.

Thus, as I have touched on already, whilst apparently recognising the ongoing significance of real-world trauma, Freud focused primarily on the individual's fantasy life and conflicts relating to infantile sexuality, Klein focused on the individual's innate destructiveness and envy, and Jung focused on experiences of the collective unconscious which follow upon the disruption of ego-functioning (I will give a more detailed account of each theorist's relationship with trauma in the relevant chapters below). Whilst all of these phenomena are related to trauma, each theorist's particular explanations and focus are largely divorced from it.

When Freud met with resistance from patients to moving on from their trauma, he understood it in terms of the negative therapeutic reaction (Freud, 1923b) and, ultimately, the death instinct (1937c), a field of exploration much elaborated on by Klein. I would suggest instead that the patient's stuckness follows from the disruption of ego-functioning implicit in trauma, as well as from the conflicting reactions to the trauma that become embedded and elaborated within the personality, powerfully influencing the nature of the individual's relationships and making it difficult to construct a coherent and effective identity. I will argue that until this conflict is understood and worked through, the individual is trapped by the traumatic complex or, to put it slightly differently, the individual is staying true to their most powerful and foundational (traumatic) experiences—even though they have little choice but to do so.

When analysts such as Ferenczi and Bowlby have persisted in focusing on the real-world trauma they have frequently been marginalised within the psychoanalytic community, although this real-world focus has been key in the development of relational psychoanalysis (Seligman, 2003). Rosenfeld's (1987) more recent recognition of the significance of trauma has been under-appreciated and sometimes criticised in psychoanalytic spheres (viz. Steiner, 1989); although this is not wholly the case—see Bohleber (2007, 2010), Garland (1998a), Peláez (2009), and others.

In a previous book (West, 2007) I explored how the psyche protects itself against narcissistic wounding—wounds to the core of the self—by throwing up narcissistic, borderline, hysteric, and schizoid defences which become incorporated and rigidified into personality organisations. However, I did not then fully recognise the primitive, affective-somatic roots of those reactions, nor did I document the individual's intricate, ongoing relationship with the trauma. This was a major omission. In this book I hope not only to rectify this, but also to present a framework that integrates the isolated elements on which Freud, Klein, and Jung, as well as Ferenczi and Bowlby, have focused, under the auspices of a larger picture which gives traumatic experience its proper place.

Having said that this book offers an integration of analytic theory, trauma theory, and relational theory, it is probably more correct to say that it offers a different perspective on each, showing how the core values of each theory address the limitations and difficulties associated

with the others. I believe that psychoanalysis, Jungian analysis, and trauma therapy need each other.

Outline and contents

Having recognised that in psychoanalysis, and Kleinian psychoanalysis in particular, any appreciation of traumatic experience is largely divorced from the individual's particular reactions to the trauma, this book puts forward a developed understanding of Jung's concept of the complex which supplies the missing link between traumatic experience and the individual's reactions to that experience.

The complex is understood to embody both the trauma-related patterns of behaviour—the internal working models (Bowlby, 1969)—as described by Knox (1999), as well as the primitive defences of the core self (common to all mammals) that are thrown up in response to trauma. These become embedded and elaborated in ways that are conflictual and make it difficult to develop a coherent identity and an effective, agentive self (Liotti, 2004a). Under the influence of the traumatic complex the individual acts imperatively to avoid the trauma and retraumatisation (as evidenced by Jung's earliest word association experiments), often calling on idealised "solutions" and ways of relating.

The book explores the way that the traumatic complex affects and dominates the personality to a greater or lesser extent. This offers a way of understanding borderline functioning and borderline states of mind in terms of the nature and degree of disruption of ego-functioning following trauma, and offers a way of delineating borderline from neurotic forms of functioning. Although both are influenced by traumatic complexes, in borderline states of mind ego-functioning (the ego complex) is disrupted to a greater extent. Whilst this book is primarily focused on working with borderline states of mind, these insights are equally applicable to working with neurotic forms of functioning.

The individual with a borderline personality organisation functions in ill-adapted ways due to this disruption of ego-functioning. These are not understood as being inherently destructive or self-destructive but rather as the individual staying true to, and recapitulating, their early traumas. This can hopefully allow the foundational traumatic experience to be recognised, understood, and worked through.

Crucially, the original traumas and traumatic patterns of relating are reflected and reconstructed in the analytic relationship in a detailed

way (Davies & Frawley, 1992a; Gabbard, 1997). This recognition offers an invaluable framework in which analyst and patient can access and know about that experience, understand what is happening in the analytic relationship, bear and understand the frequently unbearable affective experiences that are called up, and resist forms of behaviour that avoid the real difficulties (the traumas) being addressed; this avoidance can otherwise lead to an impasse or breakdown of the analytic relationship. This provides an account of the analytic relationship that sets phenomena that have usually been understood in terms of projective identification, destructive narcissism, the negative therapeutic reaction, and the death instinct, in a broader narrative frame, where projective identification is seen as one element of a wider dynamic rooted in early traumatic experience.

This framework also facilitates the analyst maintaining an analytic attitude, which enables them to stay with what the patient brings and for the patient's experience to emerge clearly into the analytic relationship.

The picture that develops through this way of exploring the patient's states of mind and ways of relating are usually readily comprehensible to both patient and analyst, and are inherently non-critical and non-pathologising. Most importantly this picture responds to the heartfelt, plaintive calls from the patient that have frequently been unheard, unseen, or misunderstood. This perspective thus offers a way of safely and effectively working with the most distressing and disturbing states of mind. It offers a way of accompanying the patient into the darkest of places and returning into the light of day—a process I liken to Orpheus' journey through the underworld in order to try to free his wife, Eurydice (Chapter Twelve).

The chapters in detail

Chapter One offers an outline of the characteristic clinical picture and some of the issues with which the analyst meets, as well as describing the limitations of existing theory. Chapter Two outlines some of the main understandings of borderline phenomena, differentiating the different ways the term has been used, and gives more detail of the clinical picture and the clinical challenges. Chapters Three and Four give outlines and summaries of trauma theory, and relational and attachment theory.

Chapter Five begins to unfold and explore the developed understanding of Jung's concept of the complex and describes how primitive defensive reactions become elaborated into narcissistic, schizoid, borderline, hysteric, and obsessional personality organisations—the upper levels of the personality familiar to psychoanalysis. Chapter Six describes the way in which trauma-related internal working models, "contained" by the complex, are embodied and expressed in the personality and, crucially, how this occurs on different levels and in conflicting forms—in direct form, as "subject" to the trauma, and in reversed form, in identification with the aggressor (please note that this term is used in two different senses in this book, as will be discussed later on). One side of this opposition is usually, initially projected onto/into others (typically, but not always, the aggressor role), thus binding the individual to the object. This reversal of the original experience is one of the elements that causes the conflict characteristic of borderline functioning, both alienating the individual from themselves and preventing the development of a coherent identity. These "ways of being with others" (Stern) or forms of "implicit relational knowing" (Lyons-Ruth) are manifested on different levels—objective (real world and historical), subjective (internal), transference (in relationship, particularly to the analyst), and archetypal (the impersonal/transpersonal, powerful, generalised patterns deriving from early experience). My experience has been that only when the trauma-related internal working models have been recognised and accepted on *all* these levels and in both direct *and* reversed forms, does the traumatic complex's domination of the personality become significantly reduced.

Chapter Seven gives a microanalysis of the analytic relationship (the transference level, mentioned above), demonstrating how these trauma-related patterns of behaviour manifest themselves and can be worked through. Chapter Eight looks at the disruption of ego-functioning and the relationship between the ego and the core self, outlining what I call broad and flexible ego-functioning—a conceptualization that challenges the classical Jungian view of the ego and offers an alternate way of looking at paranoid-schizoid and depressive phenomena. Chapter Nine looks at idealisation and sees it as intrinsic to the defences against trauma and as an attempt to avoid retraumatisation. Chapter Ten offers an extended clinical example and relates it to the theory put forward in the preceding chapters.

The following three chapters all discuss different issues related to the analyst and to analytic technique. Chapter Eleven describes the particular dynamics and pressures on the analyst to protect the patient from retraumatisation in ways that can lead to enactments, potentially resulting in the breakdown of the analysis. This is explored in relation to the mutually influencing, intersubjective nature of the relationship, and, in particular, the difficulty working with "inhuman" elements of the patient's experience. It offers an alternate account of phenomena that have been discussed in terms of defences of the self (Fordham, 1974), the x-phenomenon (Symington, 1983), or have been responded to by some relational analysts, such as Benjamin (2004), through disclosure and positively toned ways of being (see Meredith-Owen, 2013b). Chapter Twelve describes the particular "journey" that the analyst may need to go through within the analysis in order to meet the challenges that the patient with a borderline personality organisation brings; in particular, the way the analyst has to be able to deal with the defeat of their own ego-functioning, and to temporarily put to one side their ego perspective in line with the defeat of the patient's ego due to the original trauma. The chapter ends by exploring the impasse reached in Michael Fordham's analysis of his patient K, as documented in the pages of the *Journal of Analytical Psychology*. Chapter Thirteen describes how an analytic attitude is necessary in order to fully respect what the patient is bringing and safely work through the trauma, as well as presenting a reconceptualisation of the analytic attitude where traumatic experience is considered as central.

The following four chapters look at different facets of the most primitive response to trauma—the freeze/submit/collapse response. Chapter Fourteen explores the issues of shame and how the collapse response can keep the individual stuck in regression. Chapter Fifteen explores the experience of individuals who are "in thrall to the spectre of death", concentrating on experiences of annihilation and suicidal ideation which entrap the individual, relating it back to a collapse/submit response. This is contrasted with what Joseph (1982) called an "addiction to near death" and what Meltzer (1990) thought of in terms of the claustrum. Chapter Sixteen explores the fragmentation and dissociation associated with the collapse response in relation to dissociative identity disorder. Chapter Seventeen focuses on working with the primitive, dissociated, somatic elements of trauma.

Chapter Eighteen explores the way in which Jung's own early relational trauma throws light on his subsequent life experience and theorising; this contrasts with Winnicott's pathologising picture. In passing, it looks at the nature of spiritual experience in relation to what Jung described as the self.

Chapter Nineteen briefly outlines the working through of the traumatic complex and the development of the individual's ego-functioning and sense of agency; it then rounds up and concludes.

* * *

The amount of theory that this book covers is voluminous, and I do not claim that my presentation of it is in any way exhaustive, in fact just the opposite, as I have deliberately tried to make the narrative more accessible and readable, not trying to pre-empt every possible objection or charge of omission (in contrast to my practice in my first book (West, 2007), which, I felt, suffered as a result). I hope that this might leave more space for the reader to engage and debate with what I have written.

I am also aware that there is some repetition of the main themes in various chapters. This is because I recognise that it is unlikely that someone will read the book through at one sitting, but rather that readers may dip into various chapters on different occasions.

I would like to say at the outset that I have little or no interest in mindlessly categorising individuals, and certainly not of "reducing" them to mere labels. If I attempt to group together certain individuals' experiences, it is to better understand them, their distress and motivations, and what underlies their difficulties. As will become clear, in one sense the term borderline becomes redundant, as the individual's particular early relational experiences are understood to play the central role in their development and life experience. Yet even these do not ultimately "define" the individual, but rather, through understanding and working through their traumatic experience, the individual can be freed to fully develop, use, and manifest themselves in satisfying and fulfilling ways. The term borderline is, for me, left as a signifier of the particular kinds of reasons that the individual's struggle to reach this position may have been so difficult.

My abiding principle of analytic practice has been one of journeying with the patient, discovering and rediscovering the theory along the way, and I very much appreciate Thomas Ogden's (2009) viewpoint of

"rediscovering psychoanalysis". I recognise that anyone reading this book will, hopefully, challenge, confirm or disconfirm, and rediscover what I have described for themselves, in their own idiom and in their own time. I see this book as something like a map, and if I sometimes signal "Here be dragons", I hope I have sufficiently demystified those dragons, for both patient and analyst, making them more comprehensible, accessible, human, bearable, and manageable.

CHAPTER ONE

Early relational trauma and borderline states of mind

For some patients, their experience of trauma is clear and they consciously flag it up from the beginning of the analysis; however, for many others the trauma manifests in a more disguised form, in anxieties, somatic reactions or borderline states of mind, and has become embedded in their personality and ways of relating. In this chapter I will outline some of the ways that early relational trauma can manifest in these situations. In the following chapters I will address the way that borderline organisations are traditionally understood in psychoanalytic frames of reference (Chapter Two), the history and innovations of trauma theory (Chapter Three), and early relational trauma in relation to attachment and intersubjective ways of understanding human interactions (Chapter Four).

Outline

The individual in whom borderline states of mind predominate has typically experienced a profound, early relational trauma that cannot be simply "got over". Such traumatic experience sets the person at odds with themselves and the world. The experience occurring early in life, for example, of being unloved or unwanted, of being disliked or hated,

or of being deprived, ignored, or abused, powerfully disrupts and comes to dominate the individual's personality. This experience, which they cannot bear, is set at the heart of their identity and is installed in implicit/procedural memory as one of the individual's key internal working models (Bowlby, 1969).

Whilst the individual cannot bear this sense of themselves, yet if they do acknowledge it, it feels as if it is who they really are. Mostly, however, they cannot bear to accept themselves and so are alienated from their core selves, feel self-critical and self-attacking, and readily fall into envy of others. Furthermore, being foundational to their identity, they feel that they cannot possibly change, so that they feel, over time, trapped, condemned, despairing, and hopeless.

In addition, the individual will usually experience powerful counter-responses to the trauma, often mirroring, in a talion-like manner, the original traumatising ways of relating themselves, which also feel unacceptable and causes further self-hatred. There is, therefore, an intense conflict which makes constructing a coherent identity very difficult, as Liotti (2004a) describes.

Trauma is, by definition, an experience which the individual's psyche cannot bear, contain, or integrate at that time (van der Kolk, 1996b). This could be what Winnicott describes as the baby being left for too long, so that they experience, "unthinkable anxiety" or "the acute confusional state that belongs to disintegration of the emerging ego structure" (Winnicott, 1967, p. 369). The experiences that I am describing have usually occurred on many occasions over a long period. Bessel van der Kolk describes what happens when the experience is "too much":

> intense arousal ("vehement emotion" [Janet's term]) seems to interfere with proper information processing and the storage of information in narrative (explicit) memory … [so that] memories of trauma may have no verbal (explicit) component whatsoever. Instead, the memories may have been organized on an implicit or perceptual level, without any accompanying narrative about what happened. (van der Kolk, 1996b, pp. 286–287)

The free-floating, affective-somatic elements form what Jung, borrowing from Janet, called "feeling-toned complexes". These complexes incorporate both the primary, primitive defences against the trauma, and the patterns of relating associated with the trauma (the

trauma-related internal working models (Knox, 1999)). These elements, not being integrated with the rest of the personality ("having no verbal (explicit) component"), are experienced as very real, powerful, and current (often more real, powerful, and true than "ordinary experience", namely, that which has been integrated with the ego). These elements are readily triggered and associate themselves with any hook in the present, thus locating the traumatic experience very much in the here and now.

If, for example, the analyst asks the patient to wait in the waiting room before the start of the session time, or does not answer personal questions, or leaves too much or too many silences, they may be experienced as cold, uncaring, withholding, cruel, or sadistic if this experience happens to be associated with the person's early experience of the caregivers' unavailability in some way (rather than being seen "simply" as professional and clear-boundaried, as it might be experienced by someone who has not had that early experience and whose ego-functioning has not been disrupted). Such views will be held with utter conviction as the patient deeply experiences the analyst in this way.

Thus a negative transference is readily set up where the analyst is seen as cold, distant, and untrustworthy, despite whatever good or caring intentions they may hold privately towards the patient. These events—being kept waiting in the waiting room, silences, or not answering personal questions—can become the continual salt in the patient's wounds, with the patient insisting that the analyst recognise the agony and distress to which they are subjecting them. This can run to the analyst being persuaded or cajoled into making allowances in terms of waiting or silences, or trying to "prove" that they do care, that they *are* a feeling human being, and that they are not simply "following the rules" (discussed in full in Chapter Eleven).

I will be describing how it is an important part of the microanalysis of the interaction between patient and analyst, to identify what is being triggered by which particular aspect of the analyst's behaviour (Chapter Seven). This can help make sense of the experience so that it is not seen (by the analyst or by the patient) as simply an "over-reaction", as (meaninglessly) "paranoid", or as the analyst actually being cruel and sadistic. However, simply identifying what has triggered this experience will not, in itself, alter the patient's sense of the analyst (and more on what the analyst "actually" feels below). I will explore this more in the second half of the book.

These feeling-toned complexes are of such an intensity and complexity that they disrupt the individual's ego-complex. The ego-complex is that part of the psyche which orients us towards the world, holds our personal history and view of ourselves, and attempts to anticipate what will happen (although this latter part goes on unconsciously (West, 2007)). This is the feature which delineates borderline from neurotic functioning, as in neurotic functioning the individual's ego-functioning is not dominated by the trauma-related complex and is able to function in a relatively well-adapted manner—the individual can carry on to a significant extent "as normal", apparently getting over, or at least getting round, their traumas/complexes. For all individuals there will inevitably be complexes of varying power and complexity that may be triggered at certain times and under certain conditions. (For individuals with a neurotic character structure, a mid-life crisis is frequently initiated by the breakdown of the existing coping strategies which ran over the top of the underlying conflicts).

For the individual with a borderline psychology, however, their ego has incorporated these experiences into their sense of themselves, partly in order to allow them to anticipate what will happen and accommodate themselves to their traumatic circumstances. Often, these early experiences come to form core beliefs, such as, "I am too much for other people", "People do not like me" (Ogden, Minton, & Pain, 2006, p. 3) and even, "There is nothing to like, I am not a person". As time unfolds a second order of beliefs develop: "No one would like someone as negative and hopeless as me", or "It is my fate to be like this".

This "negative" experience, at the heart of the person's identity and in conflict with their imperative attachment needs, makes it almost impossible to develop a coherent identity, suited to functioning in the everyday world. Of course, whilst these defensive organisations may have assisted the individual at some point in their life, making their emotional life more manageable, perhaps through lowering their expectations of being responded to, and perhaps even saving their life in "submitting" to a violent bully, these reactions cannot just be changed through rational introspection as they have become part of who the individual is.

The person cannot bear to be who they deeply experience themselves to be, yet they cannot manage successfully, in the long-term, to be anything else. As a result they feel flawed, wrong, cursed (Balint describes this as the "basic fault"). The individual will often feel that

there is a void at the core of their identity as they cannot let themselves "be" who they fear themselves to be, for example, someone who is not liked, or is hated. Whilst they may proclaim these self-beliefs, pre-empting someone else from stating them, or in "identification with the aggressor"[1] (Ferenczi, 1932a), they cannot in practice really accept them as this would be truly unbearable. Liotti (2004a) and Meares (2012) both also understand conflicts in identity as representing the fundamental core of borderline functioning.

The person whose ego-functioning has been disrupted in this way will inevitably feel ill-adapted to the world. They can see that in order to "get on" you need to have confidence in yourself and be able to reach out positively towards others, but they just cannot congruently do so. In addition therefore, they feel a failure, bad and "no good". These experiences are confirmed with each new interaction. As I have said already, they may very likely experience a deep, agonising envy of others who (appear to) thrive, which further confirms their sense that they are bad. There may be more primary responses to the trauma/deprivation itself, such as rage, outrage, violence, or murderousness, that also leave the individual feeling that they are bad or that they have been singled out for punishment or torture. Kleinian perspectives take these inner reactions and responses to be the primary ones, as I will explore.

A therapist who does not have a deep appreciation of trauma may unwittingly confirm and strengthen these self-views in a similarly well-meaning way to their friends or family. They will point out that the world is "not really like that", that the person has no need to fear others, that they are essentially "good", and that they do have good, worthwhile capacities and qualities.

Whilst such attempts are usually welcomed at first, they are not truly believed and, frustratingly for all concerned, they do not really go in. The person comes to feel bad that the kindly reassurance (if it comes at all) does not really help, and they feel like a colander who cannot retain a good sense of themselves. Alternatively they may require the reassuring view to be continually restated, which each time is less and less effective, and leaves the person feeling increasingly dependent on the other's views. These factors give another turn to the vicious circle and are a further element in the person feeling bad about themselves.

In the long run, these well-meaning messages from friends or the analyst disconfirm the person's deepest experience of themselves and confirm that they are wrong to feel as they do. It may make them feel

that the analyst cannot really accept them as they actually experience themselves to be. Sometimes such "positive" re-framings are met with hostility, and the analyst is told that they are talking from their own enviably comfortable position and that they do not understand the patient or have the faintest idea what their life is really like.

A different response from the analyst is to point out that they may be working from a "pathogenic belief" (Weiss, 1993), that these self-beliefs are destructive, and that the person is bringing about (or at least playing a large part in) their own bad experiences. The patient almost certainly knows this already. A further step is to suggest that the patient is in some way "doing this on purpose", whether this is because they want to defeat the analyst (this might be seen as a projective identification of their own sense of failure), or whether they are manifesting a "negative therapeutic reaction" (Freud, 1923b) and "prefer suffering to getting better" as a manifestation of their masochistic tendencies (Freud, 1924c), or as an example of the death instinct in operation (Freud, 1937c). These interpretations are usually experienced as critical and punitive, even though the patient might readily join in with the self-criticism or, according to Joseph (1982), may even be unconsciously intending to induce such responses in the analyst.

I have made variations of such interpretations on many occasions and, whilst it is sometimes important to challenge the patient's corrosive, negative self-view, reframe their experiences, and help them see things in a wider context, I have found that these comments have only a limited, and frequently a negative, effect (van der Kolk describes something similar (2014, p. 128)). This is not only because the interpretation feels like a criticism and is alienating, but because it is not the kind of interaction that is helpful, and does not reflect a full understanding of the situation.

I have come to understand that in their apparently self-destructive and ill-adapted behaviour, the individual is staying true to their original, most powerful, experiences of trauma, which desperately need to be recognised, accepted, and understood. In order to really draw the poison out of the patient's early experiences the analyst has to also profoundly accept and appreciate the reality of those experiences and "locate" the original experience to which it belongs (as far as that is possible) (Chapter Ten).

This requires that the analyst learns the language of non-ego experience—the language of the defeated ego (see below), and appreciate the manner in which the exposed core self operates according to primary process functioning. This is not "pathological" in the sense that this is a normal, necessary form of functioning; however, it usually goes on unconsciously as part of processing the individual's experience. Due to the disruption of ego-functioning, it has been brought to the surface and come to dominate, so that the individual is on continual red-alert, with ill-consequences for adapted functioning.[2]

As the trauma-related patterns of interaction have become installed in implicit memory they will inevitably be reconstructed and relived in the analytic relationship. This is a co-construction, involving both patient and analyst, and I will be exploring the mysterious processes by which this happens in later chapters. Sometimes the progress of the analysis depends upon the analyst and the patient allowing themselves to participate, sometimes more, sometimes less consciously in this reconstruction, and the analysis is necessarily delayed until it becomes possible for them to safely do so. This is what I mean by accompanying the patient into the darkest places, and I hope this book will make clear the process by which this can happen.

It can lead to the individual being able to accept themselves, and to feel accepted, as they are rather than as they feel they should be, or even as they may want to be. This process may therefore entail much mourning for what they had hoped to be and what they had hoped to receive and experience—idealisation is understood as an intrinsic element of trauma (Chapter Nine)—as well as a difficult struggle to accept what happened and how they are as a result. This is not necessarily a quiet, passive acceptance, but may well include a murderous, raging, longing for revenge, as well as a wishing for the person who let them down or abused them to suffer—and at some point this will likely include the analyst.

Significantly there may be great resistance for the patient to allow themselves to behave this way towards others, similar to the way they were treated, and yet this reaction will have been constellated in them on a primitive level. It is a response that they may well find abhorrent and defend against, reacting against it when they experience it in others. Whilst Kleinians may see this in terms of the individual projecting this part of themselves into the other in the process of projective

identification, I see it, instead, in terms of the individual reacting to the retraumatising other and having to do some considerable work on themselves to recognise their talion reaction to the other—their identification with the aggressor (Chapter Six).

As I will explore further, I have found that the "witnessing" of the original trauma by both analyst and patient is highly significant. On some occasions this "simple" exchange has been almost miraculous in lifting the spell of the original trauma and allowing the events to find a natural place in the person's sense of themselves in the context of a life that is now moving forward. Freud and Breuer discovered this long ago (Breuer & Freud, 1893). It is as if the psyche has been simply "waiting for this moment to arrive", as John Lennon and Paul McCartney put it in their song "Blackbird"—a song that seems to me to sum up the experience of trauma to the core self so beautifully (with the "blackbird" being a fitting symbol for the traumatised soul). Before this point nothing has been able to shift the person's distress and prevent their anguished reliving of the original trauma.

As I have just described, most significantly, this acceptance and exploration is not limited to what the person actually experienced directly, but also to how they reacted to/against it and incorporated it within them—their primitive reactions and their identification with the aggressor. Thus a vital aspect of working the complex through is to recognise the ways the patient may enact a form of the same trauma both upon themselves and others. As I will explore in Chapters Five and Six, this recognition of the traumatic pattern of behaviour, in both direct and reversed forms and on different "levels", is often the key aspect of resolving the conflict and helping the individual develop a realistic identity out of their opposing, contradictory, and conflicting reactions.

The analyst's empathic acceptance is not, therefore, simply the analyst's identification with the patient, and a "sympathetic" recognition of the traumatic experience. Many practitioners have found that a simple identificatory attitude does not resolve the trauma but may instead reinforce the individual in a "victim" position. Such experiences have no doubt played a part in analysts concentrating instead on the patient's internal reactions, whether that is infantile sexual or oedipal phantasies in the case of Freud, or destructiveness and envy in the case of Klein. Rather, the approach I will be outlining entails an in-depth exploration of the impact and consequence of the trauma in all its forms.

As I have mentioned, a significant aspect of working with such traumas is the individual's wish for an idealised, conflict-free world where there is no possibility of further traumatisation. This is often expressed as the patient's wish for the analyst to be warm, "human", and to idealistically protect the patient, and certainly not to be bad and retraumatising. The patient's idealisation, indeed the whole dynamic, needs to be sensitively addressed as it is central to whether the analyst clearly confronts the person's traumatic experience or colludes with avoiding it (Chapter Nine); this dynamic is active from the outset of the analysis.

A defining characteristic of trauma is that is represents a defeat for the patient's ego—it was overwhelmed by powerful affect. One result of this is that the analyst has to primarily recognise and help the patient to process the patient's affective-somatic responses; the analyst's rational-based interpretations in themselves have minimal effect. This, in turn, represents a defeat for the analyst's ego and it is at this point that the analyst tends to engage in overtly encouraging or covertly blaming interpretations that are unhelpful and, ultimately, miss the point (Chapter Twelve).

Until the analyst can bear this defeat and understand why the patient cannot do what they cannot do, or must do what they must do, an impasse will remain. This is not merely about understanding but also about bearing. It raises the question of what experiences the analyst can personally bear, and the extent to which they have worked through their own traumatic complexes as, until they have done so, it is unlikely that they will feel able to "expose" the patient to something that feels, to both patient and analyst, unbearable and unresolvable. It also raises the question of the analyst's ability to trust themselves, the patient, and the analytic process sufficiently, and relinquish their own ego-functioning and "think" in the plane of primary process function and non-verbal affective-somatic modes of communication (Chapter Twelve).

Whilst the patient's thinking about their traumatic experience and their understanding and cognitive functioning in general might be impaired, this is not simply or necessarily a matter of resistance, as Freud understood it at first, or −K, as Bion would have put it, but rather an inevitable aspect of the effect of trauma on the psyche itself (see the quote above from van der Kolk). And whilst Fonagy understandably emphasises the development of the ability to think about and understand the other in the resolution of traumatic experience—what he

calls the capacity to mentalize—this can overemphasise the cognitive aspects rather than recognising the way the individual must inevitably enact their experience in the absence of a proper cognitive understanding of it.

In one sense, working through the traumatic complex amounts to nothing more nor less than expanding the individual's awareness and ability to encompass and bear these primitive, primarily somatic-affective reactions to trauma which normally occur below the level of consciousness and which induce intense shame due to the exposure of the core self and the disruption of the person's everyday functioning. This also entails recognising the upper-level, emotional and cognitive elaborations of these primitive "roots" of the personality.

Notes

1. I use the term "identification with the aggressor" in two different senses in this book; first, whereby the child identifies with the aggressor and takes themselves to be bad/wrong—the sense in which Ferenczi uses the phrase, and second, whereby the individual identifies with the aggressor and enacts the aggressive/abusive role. I hope the sense in which I am using the terms is made clear by the context.
2. I will discuss this red-alert in terms of hypervigilance (Chapter Three), and understand that the need for sameness and aversion to difference, characteristic of primary process functioning, derives from the primitive appraisal (Bowlby, 1969) of experience, which goes on from the beginning of life, in order to recognise whether this new experience is the same as previously good experience or previously bad experience (Matte Blanco, 1975, 1988; West, 2004, 2007).