Wisdom, Attachment, and Love in Trauma Therapy

Beyond Evidence-Based Practice

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3 Ego Development and Traumatic Defenses

It's a joy to be hidden but a disaster not to be found.

—D. W. Winnicott

Egoic. Defensive. Resistant. Who wants to work with a client like that? Anyone? Anyone? We use these terms inside of our profession to describe processes in the mind that are supposed to be neutral. The problem is that in the 'real' world, these words connote negativity and are more likely to be hurled at a partner in the middle of a fight than to communicate understanding. Although we as therapists are trained to take a more neutral stance, I find that therapists cannot help falling into negativity, at times, with clients that they find difficult. Often our so-called 'difficult' clients have extensive trauma histories and high ACEs scores. Traumas have consistently disrupted and corrupted early ego development throughout their difficult childhoods. Relational ability becomes compromised, ranging from tenuous to nonexistent due to extreme and chaotic dysregulation. During a successful course of trauma-based psychotherapy, these deficits in ego structure are exposed, identified, regulated, and healed relationally in the therapeutic attachment.

Ego Development

Ego has gotten a bad rap recently. In spiritual circles 'ego' is conflated with 'egotism' or selfishness and is something to be avoided or rejected, as it supposedly separates the person from a state of blissful union with the divine. Originally, though, the word 'ego' came into use in the West via Freud. This ego matures along with the brain. It mediates between the internal world (id, in traditional Freudian theory) of the person and the external world we call 'reality'. If we have a body, we need to have an independent ego in order for the body to live. For example, hunger arises in the body and informs the mind. The ego's job is to provide all of the necessary steps for feeding the body: working to get money, going shopping, preparing food, etc. All of these steps entail highly complex tasks for the ego, especially in modern civilization. One has

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to be reasonably stable emotionally, be intellectually focused, and have good planning skills to execute these steps, which correspond to competent executive function in neuroscience.

In the formative years of early childhood, there is no functioning ego. Mother[1] provides the functions and the model of the ego. When baby is hungry, Mother provides food; when upset, she soothes; when sick, she takes care of him. Nature has designed humans to be the most dependent of species because of our large brain and relatively helpless bodies when we are born. *How* Mother cares for the child is as important to the developing ego as *what* she does. If she treats baby as a lovable person while she takes care of him, the developing ego in that child will be steeped in a loving feeling towards himself and others. Loving-kindness seems to be an organizing force in the ego/mind. We can see how disorganized a child becomes who has been mothered by someone with an unhealthy or deficient ego.

Object relations theory tells us that how the caregiver behaves towards the child deeply imprints upon the child's mind and is taken into the developing personality as an 'introject'. This introject informs the developing person about their worth as an individual while also giving them a template for how to behave with others. Many of our traumatized clients not only lack positive maternal (and paternal) introjects, but actually have abusive or neglectful ones.

A client in her early 30s comes to therapy for premenstrual dysphoria. During the course of her therapy, she finds herself very worried about her safety in the presence of her therapist. She begins to have dreams about the therapist coming to therapy naked, or abusing her sexually in sessions. As this client explores her history she realizes, at first with surprise and then with acceptance, that she has no memories of feeling comfort from either parent, both of whom abused her in various and violent ways. Any rare kindness she experienced from adults happened at friends' houses or in school. Initially she cannot feel attached to anyone or any animal. She only feels connected to trees. Yet she forms enough of an attachment in therapy to continue to attend her sessions. Over many years, she develops feelings of connection with the animal world. Initially, when she dreams of animals, the dreams are tainted with a toxic feeling. One day, after several years of weekly sessions, she proudly announces that she had a dream about a mother whale and a baby whale that was loving and maternal, and she could feel the warmth of that connection.

This client was able to eventually let go of her negative introject, represented in treatment by the abusing therapist in her dreams, and embrace her first conscious positive maternal introject in the form of a mother and baby whale love

bond. This major piece of ego repair took several years to accomplish, but, once established, became a permanent part of the client's mind and reality.

What is the ego exactly and how does it come into being? I have spent a lot of time asking myself, "What attaches?" "What develops?" In some ways, the mystery of the origin of the ego is a topic better suited for philosophy or even metaphysics than psychology. Is there a primitive, immature but intact structured self that we are born with, analogous to the immature body that grows and develops? Or is the immature ego/self in a state of fragmentation that coalesces and gains organization around attachment, as Kohut postulated in the 1970s? Is the self a closed 'autistic' structure as the ego psychologists suggest, or is our primitive ego in a state of undifferentiated communion with energies, thoughts, and experiences of others?

Cultures that believe in reincarnation do not see the infant's mind as the *tabula rasa* that Western cultures do. In Paramahansa Yogananda's famous *Autobiography of a Yogi*, he reports being able to remember his infant mind:

> The helpless humiliations of infancy are not banished from my mind. I was resentfully conscious of not being able to walk or express myself freely. Prayerful surges arose within me as I realized my bodily impotence. My strong emotional life took silent form as words in many languages . . . Happier memories, too, crowd in on me: my mother's caresses, and my first attempts at lisping phrase and toddling step. These early triumphs, usually forgotten quickly, are yet a natural basis of self-confidence. My far-reaching memories are not unique. Many yogis are known to have retained their self-consciousness without interruption by the dramatic transition to and from "life" and "death".
>
> (Yogananda, 1998)

In the first postulation of ego, it is a structure or, maybe a better word would be, template that is innate in the human being. This structure is given life by being attached and in relation to other objects (people—in object relations theory). The ego develops along the lines of its likes and dislikes and the quality of attachment to others in its world. In this model, extreme trauma can 'split' or fragment the original ego, what some might call the 'core self'. The most abused clients may describe having parts of all ages, including dead baby parts, as a part of their self-structure.

Another view, put forward by Kohut in the 1970s, was that the infantile ego was actually fragmented from the beginning and evolved into greater cohesion with reality and people in its world as development progressed with a good-enough mother (primary caretaker). In this model, Mother helps the baby's diffuse consciousness to safely focus on her as a point in reality in a loving matrix. Psychopathology in the personality and trauma then manifest as a 'failure of cohesion' of a healthy ego structure.

Although paradoxical, it is possible that both theoretical approaches have validity. If we look at neurological correlations to the developing ego, we see

that the brain of children under 7 years old is highly plastic. There is an inherent essential structure, but it is highly malleable and undifferentiated with many possibilities not only for growth but also for pruning growth when the child gets to a certain age. Between birth and adolescence, the brain is in a continual process of synaptic or axon pruning. We literally 'use it or lose it'. A loving and attuned parent can help this system organize and function well, while an abusive or neglectful parent can disrupt neurological functioning and the burgeoning ego. It helps to listen to the language of our patients who will describe a 'fracturing' or 'breaking apart' of the self (split self) as well as a feeling of chaos and deficiency of groundedness in the self (lack of cohesion).

Horner's Stages of Ego Development

In my very first week of work at the League School of Boston, a residential program for autistic and psychotic youth, I walked into a training held by then director Barbara Schaechter, LICSW. She had put two things on the chalkboard. The first was this sentence: "All behavior is meaningful." The second was a timeline of early childhood development and self-cohesion from Althea Horner's book *Object Relations and the Developing Ego in Therapy* (Horner, 1975). This timeline outlined in great detail the developmental stages of the child ego from birth to 3 years of age, and the psychological deficits that were enfolded into the developing ego if the child's needs were not met in that time period. During the 70s and 80s, Horner's model was taught extensively on the East Coast and other places. To this day, she remains the only therapist I am aware of who has outlined so many stages of ego development so clearly in the young child and related those stages to casework in psychotherapy. As my wise director knew, all behavior is meaningful and explainable in adults and children when we understand the ego deficits incurred in early childhood through trauma and other adverse events, in relation to the stage of development operating at the time of the event.

The Undifferentiated Self (Birth to 5 Months)

According to Horner, the baby starts off in a state of what she called "normal autism". Because of advances in the understanding of autism, I have renamed this stage of ego development the 'undifferentiated self'. Attachment seeking is hardwired into the infant brain and begins immediately. If you put a newly born baby onto its mother's stomach, it will begin to move upward to the breast. This behavior is called 'breast crawl' and was first described at the Karolinska Institute of Sweden in 1987 (The Mother and Child Health and Education Trust, 2016). Horner describes clinical issues of this stage as a failure to attach, possibly due to neurological factors.

In the 1970s, when Horner was writing her book based on her colleagues' discoveries, the field of trauma did not exist. Child sexual abuse was considered

exceedingly rare. Pediatricians were told that the rates of incest were one in one million and that they would probably never see a case in their entire career! Widespread acknowledgment of various kinds of child abuse—physical, sexual, emotional—did not gain attention until the mid- to late 1980s. The literature of that time almost never mentions traumatic abuse as a cause of harm to the child's development.

We now know that trauma hugely disrupts neurodevelopment and attachment. The age at which trauma and subsequent attachment disruption occurs dictates what kinds of relational problems the client will have and informs therapists where we need to focus our attention in repairing these attachments.

Infants are subjected to any number of abuses. Our clients only know about those abuses if someone tells them, if they have scars, or if there is a medical history available to inform them, which, in most cases, there is not. In the 1980s, the Child-At-Risk Hotline in Boston routinely received reports of infant abuse—ranging from falling out of windows, to burns (accidental and deliberate), to shaken baby syndrome, to rape (rare, but real). What Horner and her colleagues did not yet know was the prevalence of child abuse and neglect in the psychiatric population. In her writings, issues of abuse are rarely brought up. She focuses on parenting from an attunement and presence perspective. And while it is true that an unattuned parent can be distressing to a child, severely abusive or neglectful parents can be magnitudes of order more disruptive to the attachment process.

Symbiosis (Culminates Around 5–6 Months)

During these first crucial five months, the baby is designed by nature to secure attachment with the parent in a way that can feel like a blissful fusion. The young child does not yet have a sense of difference between mother and self and a minimal sense of mother and other. Stranger anxiety does not set in until about 8 months of age. When this symbiosis is disrupted, even for very short periods of time, the infant is designed by nature to act to restore the attachment as quickly as possible. If the child cannot, the world becomes a very strange and frightening place.

Tronick's Still Face Experiment in the 1970s showed beyond any doubt that even very young infants acted with urgency to reconnect with their mother upon seeing their mother's still and unresponsive face. In the videos, we can see a child whose caretaker is instructed to still her facial expressions become shocked and saddened and then move through several stages to try to regain attachment including the following stages:

- **Reaching**: The baby reaches out physically and with facial expressions to attract the parent's attention.
- **Protest**: The baby will make noises and escalate to screeching or crying trying to push the parent in into reconnection.

- **Turning Away**: If the attempts to reconnect fail, the baby will turn away from the disturbing parent's face.

The experiments always end here for obvious ethical reasons. One can see that the child was headed into a place of shutting down, detaching, or even dissociating. As Tronick says, "We need loving contact like oxygen. We really do not have many ways to deal with the pain of disconnection at any age" (Johnson & Tronick, 2016).

During this crucial stage of development, the mother and baby engage in what is called mutual cuing. The mother shapes the baby's behavior by responding positively to certain cues, and the baby shapes the mother's behavior when she is not responding to the baby's needs by protesting or pushing. This dance is crucial for establishing a beginning trust in attachment that is foundational for the baby's perception of basic benevolence in the world. If the mother cannot or will not respond appropriately to the baby's bids for attachments and needs, or if the baby is abused during this time, a pattern of what she called 'defensive detachment' might set up. In the trauma world, we might call this dissociation.

If attachment fails at this stage, Horner describes a set of behaviors in the child or adult client that sound a lot like our modern diagnosis of reactive attachment disorder, "indiscriminate friendliness with an inordinate craving for affection with no ability to make lasting relationships," or antisocial personality, "the inability to keep rules, lack of capacity to experience guilt . . . the failure to develop the affectional bond that goes with attachment." She also describes a situation where the child can have "multiple, unintegrated attachments that are paralleled by a failure of the integration of the self-representation" (Horner, 1975) caused by inconsistent caretakers. This description sounds like the beginnings of dissociative identity disorder. A parent who is an inconsistent and chaotic target of attachment can make the child vulnerable to psychosis, or a false self that is tenuously connected to an isolated and unrelated core self. In all of these cases, the client develops extreme defensive detachment as a core character structure.

Clinically, the main focus with a client with this history (and maybe the only focus for years to come) is on creating a safe cocoon where the innermost detached parts of the client's self can 'hatch' into the light of day and attach to a safe and caring therapist, as would normally happen in the next phase of development. Horner states, "The issues of attachment and detachment in the clinical situation will be central to the treatment of all patients for whom these have been developmental issues" (Horner, 1975).

Hatching: The First of Three Stages of Separation/Individuation (5–10 Months)

With the advent of locomotion (crawling and, in some instances, walking), the child begins to leave the blissful symbiotic cocoon and explore moving away from the Mother. The awareness of separation slowly dawns on the

child's developing mind, culminating in stranger anxiety at around 8 months of age, where the child becomes aware that:

1. she needs the Mother, and
2. Mother is different than other people.

Horner's developmental view of the ego at this stage is that it is fragile and vulnerable to feelings of dissolution or nonexistence. If the child cannot locate and connect with Mother when she needs to, she may feel like her very self is dissolving and the world is literally coming to an end—a very disturbing state indeed! Horner relates this intolerable emotional state to the development of borderline personality disorder.[2] The baby will merge with the mother's energy and body through cuddles and breastfeeding in order to gain comfort and restore a sense of order and regulation in her self, body, and psyche. If the parent is inconsistent, neglectful, or abusive, or if the child is subjected to overwhelming stimuli such as pain in the body, the child cannot be comforted and brought into harmony in their body/mind. This inability to neuroregulate will follow these kids into adulthood and all their relationships, until they have the corrective relational experience that they are always seeking. The therapist provides both the container and the object for this corrective interpersonal experience.

Horner describes the main clinical failure of therapeutic work with the person here to be empathic failure. *The intense rage our borderline patients feel when we do not understand them (or they feel we do not understand them) is a result of the borderline panic that erupts when they feel their fragile ego dissolving and disappearing*. These clients literally feel like they are fighting for their lives and their sanity. This dynamic is different from ordinary dissociation and the concomitant feeling of unreality. Perhaps the self-mutilation that is common to this disorder is an attempt not just to become grounded but to *establish a sense of existence through pain to counteract the terror of nonexistence*. Suicidal feelings may not be an attempt to escape or to manipulate the provider, but to *establish congruence with a sense of nonexistence*.

When this type of client feels threatened in the therapy by abandonment, whether it is because the therapist has misunderstood them or is physically absent, a client in this panicked state will vigorously engage all the strategies for reattachment including the push/protest stage. To us it may feel like the client's behaviors comprise an unwarranted overreaction or drama. They may look manipulative or like they are acting out, but they are not. They are trying to survive. To the person suffering this sense of impending dissolution, separation (either physical or emotional) feels like a matter of life and death, sanity or insanity, or even worse, existence or nonexistence.

Practicing Period: Second of Three Stages of Separation/Individuation (10–18 Months)

By 10–18 months of age, nearly all children will have begun to walk upright. This accomplishment facilitates a huge jump in autonomy. At the same time,

a child's language will reflect a beginning sense of self with a vocabulary of 'wants' and 'don't wants'. This language is both verbal and nonverbal. At the most basic level, the child shows the parent (and herself) what she wants by moving towards it and what she doesn't want by moving away. She no longer needs to wait for her parent to pick her up and carry her short distances. Children of this age actively engage their environment, sorting out what is what for themselves. Parents tend to underestimate the abilities of this age.[3] Without locomotion, we really cannot know what is going on in the young child's head (and maybe they cannot either).

Horner describes the clinical issue at this stage of development as an inflated sense of self, or grandiosity. The child has more ideas in her head than she can safely execute. Rudimentary cause and effect thinking through exploration has begun, giving the child an expanded sense of their own capacity but without actual mastery. The child still needs constant supervision. Horner describes how the child of this age can feel a sense of magical omnipotence connected to both the elation at the sense of walking and the merged connection to the mother's power to provide for the toddler's needs. For example, the toddler walks over to the refrigerator, pulls on the handle, and the mother opens the door for her and grabs her sippy cup. Magic! Bliss! The child feels powerful and good.

A child in the practicing period will continue to develop a healthy sense of self and of their own basic goodness as long as that is what is mirrored back to the child from the parent. If the parent is abusive, the child is made to feel helpless and humiliated and risks developing a core sense of 'badness'. The mother can feel both a sense of relief and a sense of abandonment at this stage. A very disturbed parent who develops a psychotic transference towards the child cannot tolerate even the most rudimentary bids for independence and will feel abandoned by a child walking or crawling away from them. Or they can feel completely overwhelmed by the child's 'demands', which are merely expressions of biological and developmental needs: hunger, thirst, diapering, affection, need for intellectual stimulation, etc.

A physically or sexually abusive parent as well as an extremely neglectful parent can shatter and/or arrest the toddler's tenuous sense of self, resulting in ego fragmentation and a sense of extreme helplessness. One can imagine that the grandiosity of this stage could become perverted into an overwhelming sense for the child of magical badness and power, rather than goodness. The child is left then with the choice to identify with this grandiose badness (possible beginnings of sociopathic character) or reject it, if they can, by splitting it off of awareness into an emotional part or even a fully developed personality fragment (the beginnings of DID and other dissociative disorders).

Rapprochement: The Third Step in Individuation and Separation (18–36 Months)

Any parent who has raised more than one child knows that children can develop in very different ways. Some babies stand right up at 9 months of age

and start walking. Others have prolonged periods of crawling. The timelines presented here are guidelines that vary by circumstance and genetics, not hard and fast rules. With that in mind, sometime around 18 months of age the child's awareness of being a separate being from her mother starts to crystallize. By this age, Horner concludes, the child has had its omnipotent feelings and overconfidence deflated any number of times, making the child vulnerable to feelings of shame. The child starts to clearly see that power resides with the caretaking parent and that their own power is limited. It is an important moment where parenting intersects with child development. As Horner says, "The good-enough mother of this period will make it possible for the child to divest himself of his delusional power without undue anxiety or shame" (Horner, 1975).

There are many tasks associated with this age. As we have noted earlier, the very beginnings of the ego rest on want/don't want or, as Buddhists might say, desire and aversion. In the rapprochement period many ego functions develop, forming the core of the personality. These include:

1. identification with the caregivers and introjection of caregiver qualities,
2. tolerating ambivalent feelings, and
3. libidinal object constancy.

The first—identification with caregivers and introjection of their qualities—is a largely unconscious process that informs our relational choices and personality traits throughout the lifespan. Straight cisgender girls tend to identify with their mothers, and straight cisgender boys tend to identify with their fathers.[4] People say, "the apple doesn't fall far from the tree." Without psychological insight and awareness that is true. Nature does seem to hardwire us to incorporate our same gendered parent's behaviors and qualities. As I tell my trauma clients, "if you loved how your family of origin interacted, great, go with 'chemistry' and your hardwiring from your family. But if you were traumatized by them and they traumatized each other, you are going to have to rewire your personality through awareness and hard work to counteract the choices your unconscious mind will want to make."

Sometimes the identification with the parent is consciously rejected ("they were mean and I'm not like that"). *Despite this conscious rejection of the undesirable quality (meanness), the child still unconsciously takes in the quality of that parent as an introject that is alien to who the client feels themselves to be*. For example, a sweet and loving client may have a very mean internal voice with which she berates herself. She has consciously distanced herself from the mean parent's behavior and contained the mean introject from acting upon outside objects (other people), but the meanness remains in the form of emotional violence towards herself.

Ambivalence characterizes toddler consciousness. One of the great developmental tasks of the 2-year-old is learning to tolerate more than one feeling

at a time without completely melting down. Toddlers can lose it because they want all the ice cream flavors, or because they are not sure what room they want to be in, resulting in the tantrums they are so famous for. This behavior is completely normal for this age. Dealing with competing desires and aversions is no small task, cognitively or emotionally! If the parent is loving and holds a secure attachment container for the child, the child will naturally mature through this stage. When they are grown, they are able to take many points of view and hold different ideas together in the same space in their head—a skill necessary for problem resolution and relationship repair. But if complications of abuse and shaming affect this process, the child may become severely impaired in their ability to work through and resolve ambivalence—an impairment that can persist throughout a lifetime. Adults who cannot tolerate ambivalent feelings tend to see the world in black and white, their decision-making impaired by lack of nuance and frustration tolerance. These folks tend to disrupt attachment when their loved object does not live up to their sense of how things 'should' be. They can develop a narcissistic personality.

The ability of the child to tolerate ambivalent feelings is contingent on the ability to develop libidinal object constancy. What is libidinal object constancy? Piaget described 'object permanence' as the cognitive achievement of knowing that objects remain the same and do not disappear whether they are in or out of sight. Libidinal object constancy is the ability to hold a consistent image of the loved one in one's heart and mind through time and space. An adult with libidinal object constancy has internalized an image of the good parent (Freud, 1992). They can be present to their relationships even when those relationships are temporarily unsatisfying. They know at a deep level that they are loved and that people do not 'disappear' when they are not present. They feel loved and loving, caring and cared for. The task of libidinal object constancy begins in the rapprochement period with a 'good enough', emotionally present parent. If the primary parent is inconsistent, punishing, or abusive, the child can vacillate between fearing, raging at, and envying the parent. They may develop a very deep sense of shame interpersonally and not be able to feel that the world is a benevolent place or that anybody is ever 'there for them'. This type of client may not be able to hold onto any sense of caring connection during therapy breaks, such as vacations. This type of client may need a picture or voice message from the therapist over vacations. Or they may need a 'transitional object' such as a stuffed animal.

To have a separate secure identity, the child must know that there is a loving parent in their corner, consistently there for them no matter what. Most of our clients have not had this type of parenting experience, so we need to become the 'no matter what' parents, returning again and again with them to the basic 'holding environment' of unconditional positive regard during therapy sessions.

Ego Defenses

In the world of medicine, defenses are understood to be necessary and desirable. We call the body's defensive system the immune system. For the mind, the word 'defensive' has become an unpleasant term associated with arguments and war. We call someone 'defensive' when they are not listening to us, or when we do not like what they are saying. But if we look at ego defenses as the immune system of the self, we can see that ego defenses are as necessary to the safety of the healthy mind as the immune system is to the healthy body.

Sigmund Freud laid the groundwork for the concept of ego defenses, and his daughter Anna Freud developed the first lists of ego defenses and their definitions in her seminal book *The Ego and the Mechanisms of Defense* (Freud, 1992). George Vaillant, MD, a Harvard Medical School psychiatrist and professor, realized that not all defenses were created equal. He saw that some defenses were more pathological than others. Clinicians in the Harvard teaching hospitals, myself included, were encouraged to consider one of our goals in treatments with patients to be moving them up the ladder of ego defensiveness from more pathological defenses such as projection and denial to less pathological defenses such as altruism and humor, as shown in Figure 3.1. For

Figure 3.1 Hierarchy of Trauma Defenses

many of my clients this system worked well, but there were always clients that stubbornly remained at the bottom of the pyramid. In the last decade of work, I came to realize that those patients embodied the most traumatic experiences, and my view of this pyramid changed forever.

The very definition of psychological trauma asserts that traumatic events threaten the integrity of the sense of self. In many cases we hear trauma survivors say things such as,

> *My mind is broken.*
> *I feel shattered into a million pieces.*
> *I don't know who I am anymore.*
> *I can't go on living like this.*

All of these statements represent the inability of the ego to cope with the enormity of trauma that has been experienced by the client. The ego is literally overwhelmed by the trauma, and it fails, not as a moral failing, but as a structure. It gives way like a building overcome by a gigantic tsunami.

As I worked with traumatized clients, it struck me that using the pathological model of ego defenses was unkind and not strengths-based. I noticed that the greater the severity and duration of trauma experienced, the more likely it would be that the ego's 'immune system' would have to resort to stronger defenses, defenses that had been labeled 'pathological' by clinicians in a time before the advent of trauma awareness. *The greater the trauma load, the more likely we are to find people using defenses at the bottom of the ego defense pyramid.*

Consider this thought experiment:

> *You are in a prisoner of war camp where there are a variety of methods of abuse, coercion, and torture. For some things you can use your higher level defenses. You might deal with the pain of starvation by sharing your food (altruism) or laugh off the lack of hygiene (humor). As the events in camp get more intense, you may have to resort to the middle level defenses. Knowing that you can't attack your guards you might vent your anger on another camp mate (displacement) or try to develop some new skills during your time in the camp (compensation). But under extremely adverse conditions such as painful torture, none of these defenses is going to be nearly enough to help with the traumas you endure. Eventually you will resort to attempts to mentally escape through denial or dissociation, or finding substances that will alter your cognition. No one laughs their way through a torture session.*

Our clients have experienced significant episodes of extreme abuse and trauma, most often in their developmental years. Our clients are all Harry Potter, 'the boy who lived'. Their deployment of the most extreme defenses was necessary to survive the unsurvivable. Many people cannot live with the pain of a torturous and traumatic childhood, and end their lives either consciously or unconsciously. *Our clients made it through, not in spite of these 'pathological' structures, but because of them.* These defenses have been their best friends, but, like

the body when the immune system overfunctions, new kinds of problems arise along with these defenses. In the body, an overactive immune system provokes autoimmune disorders. For trauma survivors, old survival strategies and vigorous defense systems prevent them from having the loving connections with other people that they so desire—a frustrating condition for both patient and therapist. Let us consider these most intense ego defenses in a bit more depth.

Denial

We talk about denial as if it is one thing, one ego defense. Denial is actually a complex of largely unconscious mechanisms of the mind. At its most basic level, denial is an inability to digest experience through acceptance. This lack of acceptance keeps our clients turning their wheels for months to years fighting reality, fighting awareness, and fighting feelings. It is exhausting for them and for us. It is also worrisome, as sometimes our clients put themselves or others in harm's way due to their level of denial about their behavior. For example, if a parent is in denial about a perpetrator in the family, they may inadvertently expose their children to danger at the hands of that family member.

When I was writing *The Trauma Tool Kit* (Pease Banitt, 2012), I described denial through its opposite—acceptance. Acceptance is a key to healing from traumatic events. Acceptance, or nonresistance, as some people call it, must come before the abreaction and integration of self-fragments that split off during intense traumas.[5] Denial puts us in prison and tosses away the key, sometimes for decades. I have a healthy respect for denial, as all therapists must. Premature awareness of memories can lead to a total breakdown in functioning, psychosis, or suicide. The body is very wise, and denial is part of the emergency protection system of the body/mind system. Like a circuit breaker, denial throws a switch that keeps victims from completely burning out their circuits of functioning and will to live.

Even though we talk about denial in the singular, denial can manifest in several ways that incorporate other defense mechanisms (see Figure 3.2). Denial can be broken down into four types or strategies—again bearing in mind that there is very little conscious choice as to whether a client denies their experience or how they deny it. If you look at the structure of the figure, one can imagine that the sides of the triangle interface with conscious reality. Three of the types have some exposure to the outside world, that is, some conscious components. But the innermost variety is completely encapsulated inside the unconscious mind of the patient—far from seeing the light of day.

Ignoring History

We see this type quite commonly with friends and acquaintances, or in certain very structured types of therapies. It may be the type of denial that is the most conscious, although still unconsciously driven. In the past, folks who wanted to actively ignore their history or didn't consider it relevant to their current

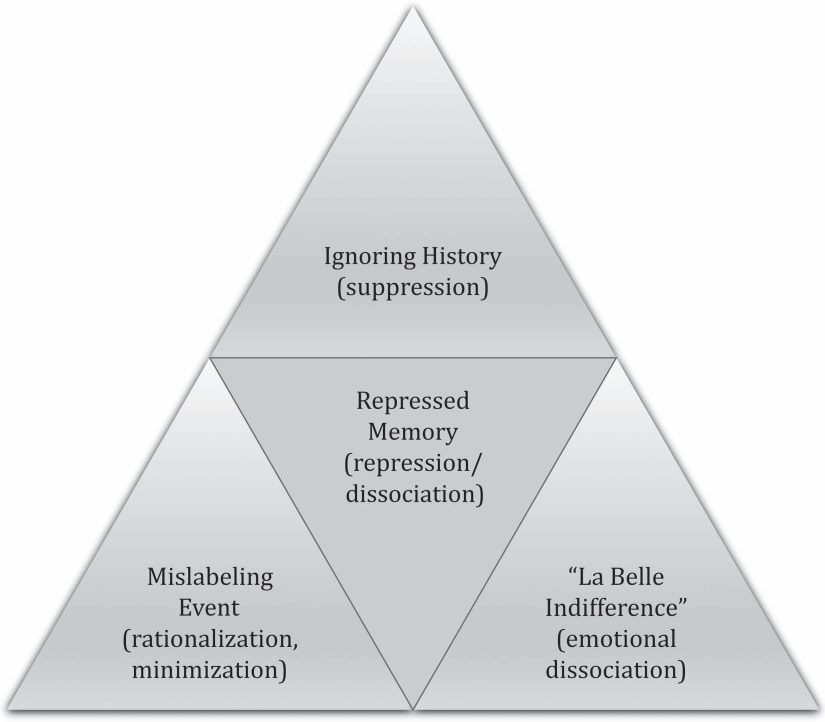

Figure 3.2 The Four Types of Denial

issues used to stay out of therapy altogether, back when therapy was defined as diving into the past to understand the present. In modern treatments such as cognitive behavioral therapy, PTSD symptoms and anxiety can be worked with directly without confronting a person's history.

A common statement associated with this type of denial is "I don't want to go back there." A person with this defensive structure will say this while still denying that there is, in fact, a 'back there'! Which leads us to another fact about the mechanism of denial—it is always full of paradoxes, inconsistencies, and discrepancies. A wise supervisor used to call this phenomenon 'bumps under the rug'—surefire indicators of a trauma history that may yet be unripe for processing.

Psychodynamic therapists might call this style 'suppression', a semi-conscious or conscious choice to avoid dealing with a painful reality, as opposed to 'repression', which is a completely unconscious mechanism. In other words, this type of client is at least aware that there is a 'back there', even if they don't want to or feel like they need to deal with those memories. You cannot reason with this type of denial. Even if the client has read many self-help books and watched hours of Oprah, they will have convinced themselves that processing memories is of no use whatsoever, and they will often try every other kind of self-help therapy available (including self-medication) before choosing to work on past

events with a psychotherapist. One sees these people, who try to heal while ignoring their history, more often doing extreme sports, changing up their diets, or walking on hot coals than talking in a therapist's office.

Mislabeling Events

These clients can describe exactly what happened to them and still not be able to acknowledge the event. By refusing to name the event, or just by not 'connecting the dots', they attempt to minimize and rationalize away their experience.

> *A client in her mid-40s comes in for weight loss issues. In the course of telling her history, she reveals that when she was in her early 20s her husband of 3 months shoved her under a chair and forced her to have sex with him. This behavior upset her very much and hurt her physically, but because of her religious upbringing she felt like it was 'her duty' to give him access to sex. She acknowledged that after this experience they 'grew apart' and she began to gain a tremendous amount of weight. She was very surprised when her therapist labeled this event a rape.*

Mislabeling can be used by perpetrators and by victims. The first task for court-ordered sex offenders at my agency was to describe what they had done to their victims in an accurate way, without minimization or rationalization. This task proved exceedingly difficult. *Victims often mislabel interpersonal traumas as children because of the way their perpetrators talk about the trauma to them in the course of grooming or abusing them*. Thus physical abuse becomes 'teaching a lesson', humiliation is 'discipline', and incest becomes 'special time' or 'doing the child a favor'.

Our legal systems influence these labels and conversations. People tend to conflate the legal severity of an offense with emotional severity. If we value emotional damage as an injustice that needs restitution, this makes sense. Sadly, the courts are always several steps behind the psychologists in awareness of what constitutes victimization and emotional damage. In court, we can end up with a judgment where a perpetrator of incest who caused emotional damage over a long period of time spends much less time in jail than an adult stranger rapist who had one offense. Common behaviors that cause horrendous psychological problems and trauma, such as a sexualizing stepfather who may look but not touch, do not have a crime associated with them at all—at least not one that is easy to take to court. 'Peeping Toms' are known in general society as a stranger offense, not as a familial phenomenon. *If our society cannot name these traumas, how can our victimized clients?* Our culture helps us name what happens to us.

Unlike the first category of people that decide they do not want to look at their history, this group knows that something is wrong in their history, and they

want to figure it out. Because they do not have the right cultural labels for their experience, they may overlook important traumas for years until an astute therapist labels them or until the culture begins to recognize and name the offense.

La Belle Indifference

Freud identified this type of emotional dissociation when he worked with clients with paresthesias, what we now call conversion disorders. It was common in his time for people to suddenly become blind or lose the use of a limb for no medical reason. A hysterically 'blind' person would blink normally if their eyes were approached but they would deny being able to see anything. What Freud found fascinating about these cases, and what made them stand apart from other types of medical illness, were these patients' remarkably casual attitude about their disability and those associated with the disability. They did not seem to care in the least that they had become blind or lame, and they did not care how it affected the people around them. He labeled this attitude *la belle indifference*, which translates from French as 'the beautiful indifference'.

I have only seen conversion disorder with la belle indifference a couple of times in decades of practice. In modern times, it is a relatively rare condition. Both times the clients were teenagers. What is much more common is to see people with a trauma history exhibit a type of 'devil could care less' emotional dissociation about their traumatic events. These clients are fully aware of their history. *They label the traumatic events correctly but have little to no affect related to the trauma*. They may deny that they were traumatized or that they need help at all, and they deny that their emotional dissociation affects their relationships.

A middle-aged man who spends most of his time in spiritual yogic practices is telling me about his family history. He says that his father was violent with all the kids in his family and that several times this man punched him so hard that he somersaulted into a wall 'like a cartoon character'. His face does not change expression, does not look sorrowful or angry as he tells me this story as one might imagine. In fact, he looks amused. He says, "I probably deserved it."

Without access to our feelings, it is hard for us to discern the reality of what has happened to us. In the case above, this person was using a mechanism to avoid negative emotions that the spiritual teacher, Ram Dass, coined as 'spiritual bypass'. Spiritual bypass is defined as the use of spiritual practices that induce pleasant blissful states to avoid rather than engage with reality, not unlike drug use. The problem with spiritual bypass, as with all forms of avoidance, is that trauma symptoms persist in the body/mind until full healing

is achieved. Until the trauma is recognized and dealt with, there is the ever-present risk of unconscious trauma reenactment in relationship.

Another cause of emotional dissociation can be the inability to actually feel one's emotions, a condition called alexithymia. This condition is not the same as autism or other disorders that can cause dissociation from feelings. With alexithymia, people cease to feel much at all, not only their traumas but also positive feelings such as joy, contentment, and happiness. People with alexithymia tend to think logically and have a constricted imagination. Alexithymia appears to be a stable personality trait and may be related to emotional neglect in childhood (Aust, Alkan Härtwig, Heuser, & Bajbouj, 2013).

Finally, there is a type of emotional dissociation that most therapists will readily recognize. Some clients have processed their trauma so many times that they cease to have any emotional connection to the event. They may never have connected to their authentic reaction at all. This phenomenon can happen after a criminal event. The client becomes desensitized to telling her story over and over to various detectives, judges, etc., without actually processing the emotional content. Emotional dissociation or la belle indifference can also be a function of having survived over a long period of time in a literal or figurative 'war zone', such as a situation of years-long domestic violence. When these clients testify in court, emotional dissociation can be a liability. Many times jurors have not believed victims because of the flatness of their affect as they tell their story.

Some therapists have not been trained in how to connect emotions in the body with patients' stories. A fully cognized trauma needs to be integrated with the body. In many cases, therapists themselves are stuck in a 'talking head' approach to therapy or their own life. A client cannot really integrate their story and their emotions until there is a great deal of trust and attachment between them and the therapist.

As a treater, I do not initially ask for the client's trauma story in depth unless there is an issue of protection (an elder, a child, etc.). I wait until they are truly ready to dive into the truth of what happened to them body, mind, and soul, a process that they initiate with me when they are ready. In fact, I will often stop people from telling their story in the beginning of treatment, especially when they are doing so out of expectation of 'how therapy is supposed to go' or if it seems they are trying to please me. At the first sign of the joining of emotion to memory, I support their integration but always without force.

Repressed Memories

In a traumatic event, the body brilliantly divides and conquers overwhelming traumatic memories into component parts in the brain, essentially fooling the brain into thinking that what occurred wasn't real. These dissociated memories are not internally recorded as part of the victim's history and self-structure. If the victim is under about 7–8 years of age, the brain is highly plastic and easily creates dissociated memories or even alternate selves in which to house dissociated memories, as in dissociative identity disorder. Dissociation compartmentalizes these memory components and helps us forget or minimize

them to reduce their impact on the system (i.e., to help us stay alive). I have worked with 5-year-olds who cannot successfully dissociate horrible memories. They try to kill themselves. The repressive/dissociative mechanism is essential for survival and is most likely an evolutionary function.

Repression minimizes or eliminates any remnant expression of the trauma in consciousness. This system of forgetting is not unlike hacking up a body and burying the parts in different places all over the county where they are unlikely to be sensed, found, or assembled. There is a snapshot picture here . . . a feeling state there . . . and a questionable narrative that the client has trouble believing. (Could my father be a molester? Nah . . .) *This division results in the client's inability to recognize memories as memories, functionally repressing them even if components of the memory never actually disappear over time*. Most of my clients have not fully repressed their memories, although this can and does happen. Most just do not recognize their memory fragments as real. **Trigger warning for following example**.

A woman comes in complaining of severe PTSD. She reports that she knows she was raped around 4 years of age, and she has the scars to prove it. She doesn't know why she has become more symptomatic lately. There is much she doesn't remember. After two years of building (and testing) our relationship, as well as exploring support and healing around PTSD symptoms, the client is ready to tell me something new. She wrinkles up her face in distress: "I don't know why I have such bad thoughts in my head. I must be a bad person to have such bad thoughts in my head." I ask her if these are new thoughts. She says no. They have been there all along, since she was a small child. I encourage her to tell me. Hesitantly she tells me about being taken into an underground structure that is very scary, very evil feeling. She talks about a crazy man doing bad things to her and other children. There are cameras and many other people standing around. She feels frozen in place and tells about the scene in a very unemotional voice. All of a sudden she comes out of the memory. Her face crumples up and she begins to cry softly, "It's so sad, so sad." "That can't be real. Can that be real? Am I crazy? Why am I making up bad things?" We talk about her very real emotional response to the scene. When she had the isolated picture in her head, there was no emotion connected to it, but now that she has shared it with her therapist she begins to experience deep grief and horror. I point out that unless she is a very accomplished actress it is unlikely she could conjure up such a real 'fake' reaction to a 'fake' memory or fantasy. Incredibly she connects so strongly to this comment that she laughs and nods her head. What she has been through is not OK, but in this moment she is OK. She is believed. She is safe.

This client actually had dissociated memory components that were never repressed (the picture of what was happening) along with feelings that were fully repressed (sorrow and horror). Up until the moment she told me about the 'bad thoughts', those components had remained separate, but they spontaneously fused in the presence of a compassionate witness. This is the magic of psychotherapy—to have a consistent and caring person listen skillfully to unbearable stories.

Ego repair lies at the very heart of wisdom therapies. To understand child development is to have the master plan to the mind and personality. To know how trauma impacts development and how it impacts the client in the here and now is to have the keys to the kingdom. You have a schema for personality development and you have the defensive structures erected by trauma, now what? Once you walk through the gates and get a look at the defenses, how do you form the attachment so necessary in therapy to the successful resolution of deep traumas? It takes two to attach. Chapter 4 addresses the necessary steps to create a solid therapeutic alliance with the highly traumatized client.

Notes

1 Please note that the author intends 'Mother' to represent any gender and any number of people involved in the early bonding and primary caretaking of the child. The combination of carrying a pregnancy to term, breastfeeding, and the constant contact of early childhood provides the traditional definition of motherhood at this stage, but is, obviously, not the only option available to parents who may be of any gender and for whom pregnancy is only one way to bring a child into one's life. In Western life, completion of this combination with one person has become a rarity, but for the purposes of writing, it will be treated as such.
2 Previous to the label of borderline personality disorder, this condition was known as borderline psychotic disorder, due to the intensely distorted interpersonal transference that would develop in relationships that were not grounded in reality. This type of patient was seen to dip and out of psychotic functioning in their relationships depending on how much support they had internally and externally.
3 I was surprised to see my 15-month-old stand in front of a series of cars in a parking lot shaking her head 'no' at each car until she got to her car, where she nodded an emphatic 'yes'.
4 We do not have much research as of yet on how LGBT individuals unconsciously identify with their parents. I hope to see more investigation into LGBT development in the coming years.
5 Usually. But I have also seen people come to full acceptance in the midst of abreaction and memory integration. Healing is a spiral, not a line, and stages do not follow hard-and-fast rules.

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