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# A Relational Perspective on Psychological Trauma: *The Ghost of the Unspent Love*

Catherine Athanasiadou-Lewis

## Abstract

Psychological trauma is central to the practice of all psychological therapies and is possibly one of the most frequently uttered terms in the history of psychology since its philosophical inception by the Ancient Greeks. Despite the abundance of scholarship devoted to the study and conceptualization of trauma, it remains a perplexing phenomenon given that the majority of contemporary studies focus on post-traumatic symptomatology and allied diagnostic pathology. While the psychopathology of post-traumatic ramifications has been thoroughly examined, the pathopsychology of trauma remains an arena of ongoing exploration and debate. The purpose of the current chapter is to offer an overview of the most predominant conceptual frameworks of psychological trauma residing in the psychodynamic school of thought, which not only addresses the intrapsychic and interpersonal origins of traumatic pathology but also provides a normative framework of healthy human development. Alongside that, a clinical case vignette will be presented to illustrate the interventions, processes, and outcome of psychodynamic treatment for complex trauma. Positioned within a post-modernist paradigm, the chapter aims to review current psychodynamic literature from a perspective that supports the notion that reality can be interpreted in multiple ways and thus embraces the diversity of multiple analytical contributions to the study of trauma.

**Keywords:** psychological trauma, addictions, psychoanalysis, attachment, sexuality, love

## 1. Introduction

Derived from the Ancient Greek word 'trauma' (=wound) and preserved in its etymological originality, psychological trauma is a phenomenon that involves an injury to the psychological matter. *Trauma* is generally defined as any experience that is felt to be unbearable that shatters the human psychic potential and affects the human capacity to relate, and feel kinship with others authentically [1]. According to Kalsched, trauma refers to a type of psychological injury to the capacity to feel, which occurs when we are given more to experience than we can consciously bear, especially if we lack resources to metabolise the mental states that emerge. Such an experience may disturb our sense of inhabiting the world in a coherent, safe, and meaningful manner [2]. As Greening quotes: *when we experience trauma, our relationship with existence itself is shattered* [3].

Traumatic experiences are broadly associated with a painful life event, which is characterised by its intensity, by the difficulty of the person to respond adequately to its sequelae and by its pathological long-lasting effects on the psychic organisation [4]. Thus, psychological trauma is the unique individual experience of a single event or enduring conditions, in which: (a) the individual's ability to integrate their affective experience is overwhelmed, and (b) the individual subjectively experiences a threat to life, psychosomatic integrity, or mental sanity [5]. The individual may be left feeling emotionally, cognitively, and physically overwhelmed, while common comorbid diagnoses associated with traumatic experiences include post-traumatic stress disorder, mood disorders, anxiety disorders, substance misuse, eating disorders and personality disorders.

The sequela of trauma commonly involves a sense of current threat, betrayal of trust, violation of psychological and somatic boundaries, loss of power, entrapment, helplessness, confusion, pain, dissociation and loss [5]. Broad examples of events that are associated with a traumatic sequela involve relatively impersonal events like natural disasters and accidents, or events of a personal character like many forms of abuse including psychological, sexual and physical assaults, wars and torture. Additionally, events of commission like interpersonal violation or events of omission like neglect and abandonment, which are not necessarily socially constructed as traumatic, may still result in the individual experiencing a sense of threat to their integrity.

The very fact that traumatisation is predominantly an esoteric, idiosyncratic experience renders notions of objectivity somewhat difficult to infer. For this reason, central to the formulation of traumatisation is an appreciation of the uniqueness of the individual's subjective lifeworld [6] and the conditions that may have been shattered as a result of exposure to psychologically wounding experiences. *It is the subjective experience of the objective events that constitutes the trauma...The more you believe you are endangered, the more traumatized you will be...Psychologically, the bottom line of trauma is overwhelming emotion and a feeling of utter helplessness. There may or may not be bodily injury, but psychological trauma is coupled with physiological upheaval that plays a leading role in the long-range effects* (Allen [6], p. 14).

At a neurobiological level, many studies have shown that the effects of environmental stress on the brain are being mediated through molecular and cellular mechanisms. Neuroimaging research findings found permanent structural changes in the prefrontal/frontal lobe volumes of the brain, as well as alterations in neurotransmitter systems in chronically maltreated children [7]. Additionally, rapid increase of dopamine under discrete or prolonged traumatic stress has been shown to cause DNA mutations in brain tissue. The main implication from these findings is that early repeated trauma may lead to permanent brain changes associated with psychopathology such as mood disorders. Even more crucially, Schore has highlighted the effects of relational trauma in the developing brain of the infant, by showing that early experiences of deprivation and neglect in the attachment system can result in an impairment of the limbic system and critical neuronal cell death, associated with future aggressive behaviour and affective dysregulation [8].

Over the years, a plethora of theoretical approaches and research studies examined the immediate and long-term psychosocial consequences of intensely traumatic events, and several psychological models have attempted to conceptualise and treat clinical presentations arising from traumatic experiences. Although psychotherapies began with traditional analytic approaches, other schools of therapy have examined post-traumatic syndromes like PTSD, including cognitive behavioural therapy (CBT), existential and humanistic counselling, dialectical behaviour therapy (DBT), and eye movement desensitisation

and reprocessing (EMDR) therapy. Effective treatments for PTSD include trauma-focused cognitive-behavioural therapies, psychodynamic psychotherapy, existential-humanistic counselling, EMDR as well as integrative psychotherapies [9–14]. With the focus of the current chapter on psychological trauma rather than on PTSD, the ensuing discussion will address theoretical contributions from developmentally focussed approaches residing mainly in the psychoanalytic/psychodynamic paradigm.

## 2. Historical overview of approaches to trauma

The relationship between trauma and mental illness was initially investigated by the French neurologist Jean Martin Charcot, who was treating traumatised women presenting with what was known as hysteria at the time (Greek *ὑστέρα* = uterus) in the Salpêtrière hospital [14]. Hysteria referred to as a set of symptoms including amnesia, paralysis, convulsions and sensory loss that would be traditionally treated with hysterectomy. Charcot observed that these symptoms may have had a psychological origin and noted that traumatic events could induce a hypnotic state in his patients and was the first clinician who captured the process of post-traumatic dissociation owing to the endurance of unbearable experiences. Charcot's student, Pierre Janet, continued to examine the relationship between traumatic memories and dissociation. More specifically, Janet studied the impact of traumatic experiences on his patients' behaviour and personality development. Janet observed an association between his patients' intense affects and their recollections or interpretations of their traumatic experiences, and found that through hypnosis, abreaction and re-exposure to the traumatic memories, patients' symptoms were alleviated [14, 15]. A substantial contribution to the early studies of trauma arose from the works of Freud and Breuer cited in [16], starting with the famous case of Anna O, who initially presented with symptoms of hysteria but was later conceptualised as a case of dissociated, repressed trauma originating in her relationship with her father. In their studies on hysteria in 1893, Freud and Breuer referred to traumatic dissociation as *hypnotic hysteria* and highlighted its relationship to a traumatic antecedent. Implementing hypnotic techniques as an initial form of treatment led to the gradual development of the psychoanalytic approach with a focus on free association, abreaction and interpretation of unconscious intrapsychic and relational processes, as central to the treatment of traumatic presentations like hysteria [14]. In working with soldiers after World War I, Freud observed that his patients often re-enacted their battle experiences and noted that traumatic dreams have the characteristic of repeatedly bringing the patient back into the situation of his accident. In 1941, Kardiner, another psychoanalyst working with U.S. veterans from World War I, also studied the aftermath of trauma and his observations resembled Freud's and Ferenczi's postulations on the nature of *re-enactment*, a construct referring to an unconscious tendency to re-experience traumatic scripts: *the subject acts as if the original traumatic situation were still in existence and engages in protective devices which failed on the original occasion* (Kardiner [17], p. 82).

The enormous impact of the Vietnam War on the psychological well-being of soldiers inspired more organised studies on trauma [14], while a growing interest in traumatisation within civilian contexts, particularly abuse and domestic violence, eventually led to the development of a diagnostic classification of trauma-related syndromes known as post-traumatic stress disorder in the Diagnostic and Statistical Manual (DSM-III) [18].



## 2.1 PTSD vs. complex trauma

Post-traumatic stress disorder was originally classified as an anxiety disorder in the DSM-III and DSM-IV and is characterised by aversive experiences of anxiety, maladaptive behaviours, somatic symptoms as well as physiological responses that arise and develop following an individual's exposure to a psychologically traumatic event. Recent reviews in the diagnostic literature now classify PTSD within the trauma- and stressor-related disorders in the DSM-5. PTSD symptomatology as outlined in the diagnostic manuals is theorised to result in clinically significant distress or impairment in several aspects of life activity, like occupation, social relations and other major areas of everyday functioning [19].

Although the diagnosis of PTSD captures a set of symptoms related to post-traumatic syndromes, it does not address developmental causes and childhood antecedents, nor does it offer a more complex and comprehensive view of intrapsychic and psychosocial stressors that exert influence on personality development and trauma-related pathology or distress [14]. For this reason, trauma has been conceptualised as ontologically different to PTSD. According to McNally, naive realists posit PTSD as an objective, timeless, universal psychobiological entity emerging in response to extreme stressors, while social constructionists assert that it is a cultural artefact arising in the wake of the Vietnam War [20]. As Young quotes: *The disorder is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources* [21].

While trauma is always an antecedent to PTSD [20], the two are not synonymous and it is important to emphasise that PTSD does not capture post-traumatic manifestations in their entirety. While all PTSD sufferers will have experienced some form of injury at some point in their lives, not all traumatised individuals will go on to develop PTSD. Yehuda and McFarlane [22] have shown that psychological trauma does not necessarily lead to PTSD but may precipitate other symptoms and syndromes. The authors propose that factors not yet well understood determine the variability of individual responses to trauma. Numerous psychiatric diagnoses in addition to or other than PTSD have been identified in traumatised patients including depressive syndromes, anxiety disorders, dissociative disorders, borderline personality, and substance misuse [21]. Chertoff asserts that PTSD rarely occurs alone and suggests that a range of trauma-related psychological problems, not fully captured in the DSM-IV framework of PTSD, occur together, requiring a more comprehensive approach [23].

Responding to the epistemological limitations and challenges of PTSD syndromes, Herman [24] suggested that 'complex PTSD' should be included as a new diagnosis that would address the multiple origins of trauma and their impact on all aspects of a person's life including personality disorders. According to Herman, the lack of an accurate diagnostic concept has serious consequences for treatment, because the connection between the client's presenting symptoms and the traumatic experience is frequently lost. Attempts to fit patients into the mould of existing diagnostic constructs generally result, at best, in a partial understanding of the problem and a fragmented approach to treatment.

More recently, Ford and Courtois developed a more comprehensive model of 'complex trauma', conceptualising it as the *inability to self-regulate, self-organize, or draw upon relationships to regain self-integrity* (Ford and Courtois [25], p. 17). Complex trauma is *associated with histories of multiple traumatic stressors and exposure experiences, along with severe disturbances in primary caregiving relationships* (Ford and Courtois [25], p. 18). Therefore, a comprehensive formulation of

complex trauma calls for a treatment model that addresses the immediate post-traumatic symptoms, which are not always limited or even relevant to PTSD but may instead manifest themselves in other clinical presentations. Additionally, the diversity of traumatic ramifications is fundamentally observed within the realm of human relationships and characterological formation. Because of the far-reaching implications of complex trauma for an individual, psychodynamic psychotherapy has been positioned in the literature as more effective for complicated types of PTSD and the broader interpersonal sequelae of trauma. Clinical and empirical evidence suggests that psychodynamic approaches may result in improved self-esteem, enhanced ability to resolve reactions to trauma through improved reflective functioning, increased reliance on mature defenses with concomitant decreased reliance on immature defenses, the internalization of more secure working models of relationships, and better social functioning [26].

### 3. Psychodynamic approaches to trauma

Much of the trauma literature in psychology has been based on classic psychoanalytic formulations [14], and later revisions include contemporary psychodynamic approaches, arising from the school of object-relations and interpersonal psychoanalysis [14–16]. In psychodynamic theory, trauma is understood to have a shuttering effect on the corporeality of the individual that requires psychological adaptation and results in a distinctive yet polymorous psychological sequelae. However, in comparison with competing theories, the psychodynamic model is distinctive in its emphasis on developmental history, unconscious function, and interpersonal processes [16].

Healthy human development throughout childhood is conditioned upon safe and stable interpersonal and contextual experiences, which shape the individual's intrapsychic dimensions and relational capacities. The interplay between the intrapsychic and the interpersonal determine to a large extent adult functioning and well-being, particularly in regards to one's sense of self and experience of the world around them [14]. Traumatic experiences hold the unique characteristic of interfering with children's natural developmental potential—that is, their ability to feel safe within their psychosomatic self and establish a sense of belonging within their human environment; to unequivocally experience mental states and authentically express them; to recognise others' mental states and empathically respond to them too; to imagine and to symbolise; to act autonomously but rely on others too; and finally to be able to love and create.

Freud's clinical observations led him to theorise that mental life is instinctually motivated by two oppositional drives—*Eros* and *Thanatos*. *Eros* literally translates into romantic love and *Thanatos* into death. For Freud, the interplay between the love instinct (also referred to as the life instinct) and the death instinct (aggression) is what produces intrapsychic conflict and results in anxiety and resultant pathology—*For it is through all bad feelings and conflicts are known* [27]. Freud chose his words with novelty. His reference to the life instinct as 'Eros' was not random as romantic love has been universally celebrated as the highest of all emotions. The idea that love is one of the most fundamental forces in the world, if not the most fundamental force, has a long and influential history [28]. Ancient Greek philosopher Empedocles argued that it was through love and strife that the four elements of nature—fire, water, air and earth—were bound together to create everything around us. Plato argued in the *Symposium* and the *Phaedrus* that love is our response to the forms—the higher form of reality, the model for everything that exists [28]. Plato defined love as *the joy of the good, the wonder of the wise and the amazement of*

*Gods*. But for Freud, the concept of love went far beyond affective experience—it necessitated an impelling function that preserved all the good for personality and civilization alike. For Plato, it is love that leads us to the forms, the ground of reality. For Freud, anything that we seek to understand and relate to, we invest with libido—in other words, we love [28]. Despite Freud's emphasis on the nature and function of the libido *per se* (the sexual drive and its symbolic expressions), he captured the importance of love both in intrapsychic and interpersonal terms predicating that love and reality are connected at the very deepest level [28].

### 3.1 Freud's theory on trauma

Freud's original *seduction theory* postulated actual sexual experiences during infancy and early childhood as the cause of all traumas and the basis for neurosis [16]. However, he lost faith in his 'seduction hypothesis' for a number of reasons: first, he came to doubt the prevalence of sexual abuse he encountered in his clinical practice, and second, during the course of his own self-analysis, his repressed sexual feelings towards his mother led him to acknowledge infantile sexuality as a driving force of personality development, from which he constructed the Oedipus complex. This revision led Freud to privilege the role of repressed unconscious fantasy and intrapsychic conflict over interpersonal factors in the development of traumatic neurosis [16]. Freud went on to distinguish between traumatic and anxiety neuroses on the basis of real occurrence versus unconscious fantasy and the resultant intrapsychic conflict (e.g., desire versus rage). According to Freud's clinical evaluations, the pathogenic agency was invested in the memory of the trauma and the patients' defences to tackle the emerging anxiety like denial, repression and dissociation. A discharged affect of the attached traumatic experience usually resulted in these memories transforming into tolerable ordinary recollections, accessible to the conscious mind. When a reaction discharge was, however, impossible, then these affectively undischarged memories were theorised to enter a *second consciousness* where they became secrets, either isolated from the conscious personality or available to it in a highly summarised form and often unconsciously acted out [29].

A related interpersonal observation was that of 'traumatic re-enactment'—the human tendency to repeat earlier patterns of relating in an attempt to master the conflict arising from the repressed, traumatic experience. Freud captured this phenomenon in his early writings on 'remembering, repeating and working through' [30] and termed it *compulsion to repeat* (Freud [30], p. 151). Attending to his patients' relational patterns using free association, Freud discovered the notion of transference, a relational phenomenon whereby the therapist (and other important people) symbolically represented a figure from the patient's past. By closely attending to the manifestations of the transference (e.g., how the patient treats the therapist, their expectations, wishes and anticipated roles) and gradually interpreting its aim (e.g., a wish to dominate an abusive parent by overpowering the therapist), Freud was the first clinician who attributed therapeutic change to the processes of the therapeutic relationship. *We must be prepared to find, therefore, that the patient yields to the compulsion to repeat, which now replaces the impulsion to remember, not only in his personal attitude to his doctor but also in every other activity and relationship, which may occupy his life at the time-if, for instance, he falls in love or undertakes a task or starts an enterprise during the treatment* (Freud [30], p. 151).

In addition to Freud's attendance to intrapsychic conflict and fantasy, the role of external traumatic experiences has been widely highlighted in the writings of many classical psychoanalysts including Carl Jung, Sandor Ferenczi, Anna Freud and Alfred Adler, all of whom emphasise the reality of early childhood traumatic experiences and their impact on the formation of mental representations of *self*



*and other*. Followers of Freud like Klein, Winnicott, Fairbairn and Bion developed his original model further and included the realm of human object relations, which is the centrality of relationships, particularly attachment processes and infancy experiences, in the formation of personality and character pathology following trauma.

### 3.2 Fairbairn's theory

A significant departure from Freud's conceptualisation of libido was offered by Ronald Fairbairn who believed that the libido was not *purely pleasure seeking* but *object seeking*, and as such, Eros could be understood as a drive for relational gratification [31]. When libidinal urges become thwarted in childhood, either via the frustration of the child's dependency strivings or because the child's efforts to establish affirming and safe interactions are not met in a reciprocal fashion by the care givers, the child turns away from external reality. *In place of those connections, the child creates a fantasy world of internal objects that contains features of the real-world objects with whom the child cannot establish and maintain a meaningful relationship* (Ringel and Blandell [14], p. 67).

Drawing on his work with abused children and schizoid presentations in adulthood, Fairbairn noted that traumatic experiences in infancy cause the developing child to feel unloved as a person in their own right and also to interpret their own love towards the caregivers as essentially bad, worthless or destructive. The child then absorbs the parental characteristics and identifies with the unresponsive features of the parents: isolated, depressed, masochistic, bullying and self-destructive [14]. Fairbairn asserted that by internalising these pathological character traits, the child re-establishes a connection to the parent, who is unavailable in other, healthier ways. *This type of internalization of the parents also necessarily creates a split in the ego: part of the self remains directed toward the real parents in the external world, seeking actual responses from them; part of the self is redirected toward the illusory parents as internal objects to which it is bound* (Mitchell and Black [31], p. 120) [14]. Traumatic re-enactments in subsequent relationships were thus associated with the painful sequelae of the object-seeking behaviour.

### 3.3 Ferenczi's contributions

Ferenczi's contributions to the theory of trauma equally favour experiences of exogenous nature and their exerting influence on personality development. Ferenczi studied phenomena of regression, repetition and acting out in treatment with abused patients, and apart from his emphasis on dynamics of the real traumatic relationship between the child and the perpetrator, he highlighted another important traumatic phase: the denial of the traumatic event by significant people in the child's life, most notably the child's mother. For Ferenczi, the environmental rejection of the child's living nightmare represented the most pathogenic component insofar as the child's reality was inadvertently invalidated, thus enhancing dissociation and depersonalisation leading the child to resort to distorting their own reality in order to survive. The problem with this type of defence is of course what Freud always referred to as the *return of the repressed* in the form of neurotic symptoms [14, 16, 32].

### 3.4 Winnicott's contributions

For Winnicott, the experience of trauma is central to the development of the 'false self', which comprises an inhibited, fragile and often hidden sense of identity,



akin to an insecure attachment system, with an impoverished capacity for trust and authenticity [33]. In Winnicott words: *I find it useful to divide the world of people into two classes. There are those who were never 'let down' as babies and who are to that extent candidates for the enjoyment of life and of living. There are also those who did suffer traumatic experiences of the kind that result from environmental let down, and who must carry with them all their lives the memories of the state they were in at moments of disaster. These are candidates for lives of storm and stress and perhaps illness* (Winnicott [33], pp. 123–124).

Winnicott wrote that babies enter life with an 'inherited potential' for a 'true self' that reflects their existential essence [34]. In 'the holding environment' provided by an available, containing, responsive and emotionally attuned maternal figure, the baby's authentic, spontaneous expressions originating from the Id, develop and their sense of identity becomes firmly established. Infants, on the other hand, who are exposed to repeated deprivations or impingements, do survive but at the cost of 'living falsely'.

For Winnicott, the false self is a necessary facade that the child erects to secure the mother's love by being compliant with her inadequate adaptations or unconscious expectations. For example, a depressed mother might prematurely force an infant to be 'cheerful' and 'strong' by projecting all of her unconscious wishes for rescuing onto them; a child of very angry, unstable parents might be terrified from expressing any of its own darker emotions or a child of intrusive parents might be prevented from developing a capacity to be alone and regulate their emotions.

Winnicott's observations uniquely highlight the role of relational trauma in personality development, which is often subtle and invisible to 'the bare eye' as it does not necessarily encompass the drama of sexual or physical abuse and their visible scars, but instead runs within the psychic vein like a colourless poison.

### 3.5 Kohut's self-psychology

Kohut's self-psychology framework encompasses a novel model for understanding normative human development and developmental deviations, as well as a theory of psychopathology. At the centre of Kohut's theory is the idea that healthy personality development presupposes the satisfaction of core narcissistic needs within the attachment system, such as the need for mirroring (building a coherent sense of identity), idealisation (establishing self-esteem) and twinship (fostering a sense of belonging) [35]. Kohut viewed psychological disturbance as both originating and resulting in deficient self-functioning, manifesting in a variety of forms (e.g., borderline conditions, pathological narcissism and other personality disorders as well as depression, anxiety disorders and sexual perversions). Kohut formulated these conditions as the result of chronically occurring, traumatic breaches in parental bonds, most notably in empathic failures [14]. Unlike many object-relation theories in which maturity is equated with separation and individuation, self-psychology sees the developmental line of self-object relations as extending from birth to death [14]. Thus, self-psychology is predominantly an interpersonal approach that addresses intrapsychic development on the basis of how core narcissistic needs are being met within the attachment system.

### 3.6 Bowlby's attachment theory

The origins of attachment theory are found in Bowlby's idea that the relationship of close proximity between the infant and the primary caregiver serves not only as a survival mechanism, but it also allows the infant to develop socially and emotionally. In other words, the close proximity to protective caregivers keeps

the child safe during threatening times, while psychologically it creates a sense of 'secure base', allowing the child to explore the environment. Influenced by object relations, Bowlby developed the concept of internal working models (IWM) to describe the representational models of self and others stemming from the quality of early bonding experiences. Traumatic attachments characterised by experiences of abandonment, physical or sexual abuse, neglect or parental indifference are theorised to hinder various domains of psychosocial development, such as romantic and peer relationships, disturb affect regulation, and damage the self-concept [14, 16]. Contemporary psychoanalysts, Fonagy and Target, introduced the term 'mentalisation' to describe one's ability to comprehend mental states in self and others (e.g., thoughts, feelings, intentions, and wishes) and developed a model that linked insufficient mentalising capacity to a pathological self-originating, in traumatic attachment, experiences [36].

#### **4. Clinical vignette 'Olivia: the ghost of the unspent love'**

This section will present a case study summarising elements of psychodynamic treatment, process and outcome with a particularly challenging clinical presentation of substance misuse following developmental trauma. To preserve confidentiality but to maintain originality of the essence of treatment, all identifying details have been replaced with fictitious information. I borrowed my title from a novel written by Maro Vamvounaki in 2008 *The phantom of the unspent love*, which uniquely highlights the intricacies of inner deprivation and psychic unfulfilment, in an era where satisfaction is pursued at all costs. As the novelist highlights: *Love is indeed the great completion of the existence, but only when it's about the love that you give.*

##### **4.1 Olivia**

Olivia was a 48-year-old consultant cardiologist who sought therapy following years of opiate dependency syndrome and episodes of recurrent depression. Olivia's distinguishing talent and formidable skill led her to a nomination to specialise as a heart surgeon, but due to her concealed heroin addiction, she 'settled' with cardiology alone (mainly teaching coupled with part-time consulting), acknowledging the potential risk involved were she to perform open heart surgeries. Olivia developed an addiction to smoking heroin (but never injecting) during her medical training and saw it as a way of forming peer relations and getting a sense of belonging when she was studying. Prior to smoking heroin, as a child, Olivia used to enjoy inhaling white spirit and reported doing so since the age of 9, when she started attending painting classes and spirit was largely available for art purposes. Her bizarre inhalant addiction went unnoticed by her immediate environment, and in the same fashion, Olivia kept her ongoing heroin abuse hidden, by controlling withdrawal symptoms before they would kick in. Olivia took substantial, intermittent breaks from her substance misuse that allowed her to maintain a reasonable level of professional and social functioning, but she eventually relapsed into her original habits, getting stuck into the vicious cycle of withdrawal and submission into cravings.

Olivia described a 'normal' childhood with plenty of material goods and toys, albeit dominated by parental conflict and fought relations within her family. She had some fond recollections of her mother as an affectionate and emotionally attuned figure but also described her as highly critical and controlling, often intruding into Olivia's space leaving her feeling anxious and hypervigilant. Her father, on the other hand, was described as a remote and somewhat mysterious figure, whose main interest was his business and professional success. Her father was also

described as the main source of stability in the home, and Olivia admired him for his physical appearance, wealth, moral values, and for offering them a comfortable, middle-class upbringing. Olivia had very little recollections from her childhood overall and the father in particular, as after the age of 9, he started travelling abroad a lot and so his presence was not felt in their home but was not missed either.

Her mother portrayed the father as cold and indifferent and frequently accused him of cheating on her (without evidence), causing her to feel neglected and chronically depressed. Olivia would often console her mother's depression by keeping her entertained and by minimising the impact of her own neediness on her, by withdrawing or presenting content, despite feeling otherwise. Both parents held high aspirations from Olivia, and they hoped that she would study engineering in order to take over the family business in land development. While Olivia complied with their wishes and strived to please them, she chose a medical career instead, as she could not stand the thought of inheriting the *family traditions*.

Olivia also reported having a half-sister (from her father's side) 10 years her senior, who died of an epileptic seizure when Olivia was only 6 and once again she reported very little memories from her or the period following her death. In fact, Olivia emphasised that the only connection she had with her half-sister was through a family album and stories she heard about her, without any real affective or mnemonic account of her own. Her half-sister did not live in the family home and this is how Olivia explained the gap in her memory.

As an adult, Olivia consumed herself in short-term romantic relationships with 'handsome and high-status' men, but struggled to form intimate bonds reporting a feeling of suffocation and an aversion to co-dependency. She never married or had children, lived on her own and was fully dedicated to her career. Despite her professional success, social recognition and physical attractiveness, Olivia reported a chronic sense of emptiness, prolonged melancholia that was only interrupted by long-haul vocational activities, and a bizarre sense that she was fundamentally unloved. While she enjoyed conquering and dominating her lovers sexually, she reported episodes of anorgasmia (which she would also hide well in an attempt to get her lovers' complete surrender to her sexual charisma and achieve a narcissistic triumph).

More recently, she disclosed that she always had moments of silent crying during sexual intercourse that she would master by ending these relationships before they would develop into something more meaningful. Olivia sought therapy mainly to target her substance misuse as she became acutely aware that the use of heroin was serving a self-preservatory purpose that instinctively began to feel at odds with the causes of her existence. Olivia always maintained that she never suffered any trauma or abuse as a child, and became curious herself about the psychological origins of her long-term battle with addiction.

While Olivia struggled with her immediate recollection of her childhood memories, the material that we held was enough to explore the function of heroin as an object relation that would perform the soothing and self-regulatory functions the internalised object failed to successfully perform [33, 34]. Attending to her insecure attachment style and her relationship with her mother in particular, led us to identify Olivia's unmet narcissistic needs as a child, in terms of self-object experiences [35] and how heroin would offer her the emotional tranquillity that she was so desperate for, but unable to provide to herself as an adult, in the same way the internalised mother failed to meet her child ego's empathic needs.

Davies and Frawley assert that the traumatised child's loss of a secure base may constitute *the most pernicious and damaging psychological trauma*. Because clients' internal worlds contain partial or no representations of loving, protective objects, they never fully develop the capacity for self-soothing and self-calming at times



of distress or for containment of the anxious states, disorganisation, and intense hyperarousal [37]. Relatedly, growing up with a depressed mother, Olivia's main endeavour was to save her from her demonic occupations assuming the role of the hero (often successfully as that kept her mother going) but at the expense of establishing a coherent sense of self with an *idealised internal other*. Not being able to idealise a depressed and miserable mother, Olivia had no hero for herself and *heroine* by virtue of name and quality, symbolically satisfied that unmet narcissistic need for her [35].

Attending to this transference dynamic and interpreting the re-enactment within our relationship were paramount to the healing process. Olivia would often become acutely aware of any signs of vulnerability in me, and her immediate reaction would often involve some type of kind offer to enquire into my own shortcomings (Much of those offers were products of the transference in fantasy, in the absence of any real vulnerability on my part.) I often hypothesised whether she initially aspired to become a heart surgeon because she wanted to fix the mother's heart and gain the love she was so desperate for. Olivia related to this interpretation well, noting the unconscious motivation behind the choice of her medical speciality, but she equally reported feeling loved by the mother despite her somewhat traumatic attachment to her. Rescue fantasies often occur as a result of parentification in childhood and are frequently repeated in adult relations where individuals enact the role of the hero in an attempt to achieve a narcissistic triumph and maintain the conditions of love they were initially subjected to, during childhood [35]. Rescue fantasies, however, also serve to unconsciously disavow the intolerable vulnerability of the wounded child's ego state and aspire to create a dynamic where the rescued object is finally well enough to serve their own needs (representing the weak parent in the transference).

Winnicott captured the tremendous essence of growing up with a depressed mother in his poem 'The tree', where he illustrated the intricacies of the development of the false self. Indeed, Olivia struggled with her true self expressions in all facades of her adult life and emphasised how she would receive a sense of narcissistic gratification by being admired at work, saving her patients and being desired by men, but she never managed to feel loved for who she truly was. The therapeutic space acted as a new maternal, holding environment, and during the process, we utilised Kohut's ideas of empathic resonance and attunement as the therapist's primary mode of listening, and a focus on affect as an essential component of Olivia's internal experience, which gradually aided her to build a more coherent sense of self that strengthened her capacity not only to mentalise but also tolerate her own emotional states (previously 'anesthetised' by heroin). This was accompanied by a reduction in the use of heroin and a stable compliance with her methadone schedule.

By the second year of treatment, Olivia had already managed to maintain a stable drug-free regime and demonstrated a better capacity to regulate her affective experiences, despite relying on methadone and occasionally on legal anxiolytics. However, the relinquishment of her dependency from the drug unveiled Olivia's core traumatic depression, and while her feelings of emptiness lessened, her sense of reported 'unlovability' became so raw that drove Olivia to form even more intense and rough sexual encounters whose only aim was pure libidinal gratification. It was almost as if an invisible force compelled her to seek immediate and unnegotiable physical proximity. But while she would report momentary narcissistic satisfaction from her lovers' surrender to her physical tricks, all attempts at intimacy from prospective partners were met with what she termed 'terror' and an ensuing frantic escape into a schizoid retreat. In 'a moment of meeting' [14] with Olivia, I captured her desperation inside of me in the countertransference, which I



only released when I declared the annulment of all of my previous interpretations regarding the unconscious motivation behind her intense sexual activity in the absence of attachment. *Olivia was not seeking to receive love per se to satisfy a deficit in erotic resources, Olivia was seeking to grant love driven by an erotic surplus, in an attempt to re-unite with the lost object and secure her existence.*

Love has been at the heart of philosophy, psychology and psychoanalysis since conception, but sadly often trivialised by contemporaries, due to the emphasis either on the individual's *libidinal urges* as core motivators of mental life, or *relational drives* to secure survival. However, a distinguishing feature of the psychoanalytic approach is the awareness of the link between adult love and love in infancy [29].

Freud, cited in [29] postulated two models of libidinal relation—the initial narcissistic love of the ego (e.g., the mirror image sought in the other) and the anaclitic love of the object (e.g., the image of a parent). It could be argued that both types of love are anaclitic in nature as the individual requires mnemonic access to earlier patterns of relating to self and others for the repetition to occur, either pre-consciously or unconsciously. In 1912, Freud referred to love as an *affectionate current* akin to long-term attachment and differentiated it from sexual desire, which he referred to as a *sexual current*—both referring to a propelling, dynamic energy in the psyche. According to Freud, the split between *affection* and *desire* is experienced unconsciously in order to defend against punitive parental introjects, which are awakened by the experience of a new desired object in a sexually similar way as the subject felt towards the desired parent in childhood [39]. Freud referred to this as the *mother-whore* complex in male love, to illustrate the inability to maintain sexual arousal within a committed, loving relationship. This is, however, true for all relations. Clients with this complex desire a sexual partner who has been degraded, while they cannot desire the respected partner: *where such men love they have no desire and where they desire they cannot love* [38]. The person then develops two specific self-protective unconscious defences:

- a. The first is an ascetic attitude towards desired objects in which disgust and humiliation are subliminally employed to thwart self-expansive, romantic urges.
- b. The second is a moral masochistic reaction of guilt in the wake of desire. The person unwittingly assumes that yearning for new objects of desire is an act of disloyalty to parental introjects. To avoid this primal sin, the person seeks to evoke rejecting responses from the desired object by pushing them away. Interpersonal hurt then disrupts the transfer of incestuous impulses from a parental introject onto the new object. According to Freud, to defend against additional infantile patterns—repressive, seductive, magical longings for the 'lost' object of the parent-child bonding—moral masochism and asceticism work together, alternating in dominance [38].

In Olivia's case, however, the process of erotic connection with the potential of leading to deeper intimacy was evoked by the thwarting of her own loving urges—not her partners' evoked rejection, who on the contrary demonstrated an eager and often affectionate attitude towards her. In fact, Olivia's attraction would immediately cease once the desired lover would attempt to transform into an affectionate partner.

Secondly, Olivia's comfort with sexual proximity was anything but ascetic. Her compulsive hyperarousal, in fact, served to enhance the split between affection and desire in as much as desire for anonymous objects (short-term flings) would compensate for the lack of affection for an eponymous subject (long-term,

stable attachments). The wake of the potential of affection towards an admirable and respected partner seemed to overwhelm her ego, sending her into a one-way schizoid retreat. Fairbairn observed that the schizoid's main conflict lied in the individual's perception of their own love as 'bad' and Olivia's moral masochism manifested in the halting of her own expressions of affection towards the subject, not the other way round.

The next logical question was 'why'. There was nothing in Olivia's narrative that would point to an earlier oedipal, traumatic experience that would account for the internalisation of her own love as destructive. I had already attempted to make a link between her father's absence and her avoidant attachment style, which could have in part explained her distaste of bonds, but Olivia did not react with any substantial insight into that either. Having no material to work with from her earlier history and being confronted with Olivia's severe depression, left me with no choice but to attend to her current acting out as the last resort to make sense of her suffering. Olivia continued to report outbursts of silent crying during sexual intercourse and affirmed her feelings of 'terror' every time a prospective lover invited her to reciprocate love in the form of relational affection—that is, every time the erotic physical yearning threatened to become an erotic relation.

During the later stages of treatment and while following this line of enquiry, Olivia met an older man who fell in love with her and resisted her continuous rejections by persevering into creating a long-term relationship with her. Olivia's depression worsened over the coming weeks and she eventually relapsed into heroin, and suffered a myocardial infarction. Her heart was about to stop and she would no longer be confronted with the pain of needing to give love—the ghost of her unspent love would be long gone.

Olivia suffered a heart attack on the grounds of a hospital a few minutes before she was due to start work and was found immediately by a fellow doctor who proceeded to transfer her to the emergency room for resuscitation and emergency angioplasty. When she returned to therapy 6 weeks later, Olivia reported the following experience:

Following the coronary angioplasty and during the process of arousal from the general anaesthesia, Olivia entered a semi-conscious state where she began to recount memories from her childhood. This continued throughout her recovery process in the coming weeks where she was bombarded with lucid images from her past. Olivia recalled herself as a child visiting her half-sister's house with her father, where she would be left to play on her own in the garden, while he would spend time indoors with the half-sister. Olivia recalled herself looking through the glass door into the living room and seeing images of her half-sister who was a teenager at the time, entering vague sexual encounters with the father. At the time, none of the scattered nude images or their proximal physical postures arising from gaps in the curtains made sense to her but evoked a strong feeling of terror. Olivia also remembered hearing her half-sister declaring her love for him on numerous other occasions and him demonstrating a bizarre, adoring attachment towards her. Olivia remembered attempting to ask her father about physical love between people and being heavily reprimanded for making such unacceptable enquiries. Olivia remembered feeling scared but forming a clear understanding at the age of 6, of what Eros meant, and what falling in love feels like. Olivia remembered sensing a confusing arousal inside her 6-year-old body—a precocious maturity. Olivia remembered telling her mother that she was scared of the father and her mother dismissing her. Olivia remembered that her half-sister died suddenly of an epileptic fit and that her father entered an inconsolable depression after that. Olivia remembered her father travelling abroad all the time following the death and being completely absent from her life. During his inconsistent returns home, Olivia remembered her

father visiting her bedroom after midnight and her whole body shaking with terror, freezing into the foetal position. Olivia did not remember any sexual encounter with the father she admired, respected and loved, but remembered picturing the full meaning of love:death. Olivia painted many pictures of lovers that die in lust, at her after-school painting club, which she would often erase using white spirit.

## 4.2 Discussion and outcome

In the proceeding sessions, it was made clear that Olivia's trauma had been dissociated from her conscious mind but fully absorbed and acted out in child play, in her behaviour towards adult relations, in her belief system and in her attachment style. Ferenczi illustrated how sexually traumatised clients may have little if any memory of the event largely due to the disbelief, minimization, and denial exhibited by adults in the child's environment, whenever efforts were made to introduce the topic of seduction. In tandem with the child's desire to maintain some sort of loving connection with the parents, these reactions are further reason for the child to disbelieve their own veridical recollections and to conclude that the seduction imagined was simply a fantasy production [14]. However, the memory of the veritable seduction experience and the resultant trauma do remain, creating a fragmented personality, in a way that each split or division in the personality behaves as though *it does not know of the existence of the others*. According to Ringel and Blandell ([14], p. 45) *what is especially remarkable about this portrayal is how well it resonates with contemporary psychological formulations of the processes and phenomena of dissociation, now universally recognized as a hallmark of the post-traumatic adaptation* [14].

For Olivia, the operation of dissociation primarily allowed her to tolerate the reality of the distressing event by splitting off highly incoherent or overwhelming thoughts, memories and feelings [29, 32, 37] associated with witnessing her half-sister's incestuous relationship with the father. The task of therapy was to help her integrate these memories into her personality while increasing her capacity to tolerate and process the affects and interpretations associated with the traumatic experience. Ringel and Blandell [14] quote Davies and Frawley who noted that *with no self-reflective observing ego to provide even the rudiments of containment, meaning and structure to the traumatic events, the child exists in a timeless, objectless and self-less nightmare of unending pain, isolation and ultimately, psychic dissolution* (p. 75). According to the authors, it is not just the traumatic memories that become dissociated from other experiences but also *the organization of mutually exclusive systems of self and object representations* (p. 75) formed in relation to traumatic experiences. The therapeutic process, as a result, must achieve integration not only of the memories themselves but also of clients' varying experiences of self in relation to their fragmented worlds of internal objects [14].

The concept of enactment was necessary and instrumental in Olivia's treatment outcome in as much as it offered us a platform to observe the unconscious repetition of her primary relational and intrapsychic conflict, which led to the eventual dissolution of the dissociation and her successful abreaction of the trauma. As mentioned above, a central conundrum of Olivia's traumatic depression was the split between her sexual behaviour and her attachment system—a dichotomy between desire and affection. Olivia seemed to have internalised a very antithetical vision of her father both as an oedipal object of desire, and as an attachment figure of resourcefulness and *potential* security. Witnessing the sexual incest and the simultaneous enmeshing attachment between her half-sister and her father, which was eventually interrupted by her death, led Olivia to develop a series of fantasies associated with her own capacity to express sexual desire and loving affection. In the final stages of treatment, Olivia was able to articulate how love, both in the



form of affection and desire, threatened to bring about some sort of disaster (i.e., psychical death) in the same fashion her half-sister died for entertaining both internal states. Moreover, her father's subsequent distant attitude led her to fear the consequences of her own affectional loving urges (possibly by introjecting his own incestuous guilt) and the safest way to prevent the impending catastrophe was to keep desire and affection separate. However, her compulsive urges to enter intense sexual relations were a reminder of her own uninvested or unspent love, and her failure to achieve a satisfactory outcome in terms of developing a lasting relational bond was possibly the most alerting signal of the enormity of her dual conflict: the intrapsychic vs. the interpersonal. According to Eagle ([39], p. 221) *One classic and primary expression of an inadequately resolved Oedipal conflict is a relative inability to integrate sexual and lustful feelings on the one hand and tender and loving feelings on the other, that is, to have both sets of feelings towards the same person. One consequence of such an unresolved conflict, which often brings people into treatment, is great difficulty in establishing and maintaining long-lasting intimate relationships.*

The relationship between sexuality and attachment is not fully understood yet but contemporary theorists have attempted to shed some light on it by presenting it mainly as a parallel and antagonistic process facilitated by two distinct subsystems [40, 41] or as intertwined co-occurring systems that require integration for patients who might have suffered trauma [42]. The latter seems to be a more plausible explanation of the processes of attachment and sexuality in trauma, as the complete separation of the two, admits to a number of limitations, which go beyond the scope of this chapter. Eagle [41] supported the view that attachment and sexuality are functionally separable systems and, in certain respects, operate in mutually antagonistic ways. He further proposed that the integration of attachment and sexuality is a developmental challenge that is met by different people with varying degrees of success depending, in part, upon their individual attachment pattern. With regard to Freud's postulation of moral masochism stemming from incestuous longings, Eagle correctly argued that whereas an incest taboo is relevant to understanding the split between love and desire, there is little evidence that universal incestuous wishes play a central role in accounting for that phenomenon [41]. Holmes [39] noted that it is not uncommon for partners to be intensely attached to each other with a relative absence of sexual interest and conversely that sexual involvement may preclude an attachment relationship. Fonagy also remarked that these systems are separate and at most loosely coupled [39]. Diamond emphasised this separation by noting that *desire is governed by the sexual mating system* (p. 174), the goal of which is reproduction, whereas *love is governed by the attachment or pair-bonding system...the goal of which is the maintenance of an enduring association* (p. 174) for the purpose of survival of dependent offspring [43].

While these observations hold tremendous theoretical value, they do not account fully for the intertwining between the two, given that Eros does not necessarily aspire to reproduction, but to other forms of connection including intimacy and unity. The latter is especially true for same-sex desire where the innate reproduction code is intact, but does not drive sexual longing *per se*. Kirkpatrick pointed out that the need for intimacy seems to be greater among women than men in homo-erotic relationships, and that genital release may not be their primary organising and motivating factor.

Moreover, we do not hold sufficient research outcomes to validate the claim that some sexual relations do not involve an attachment relationship at all. It may well be the case that the attachment dynamic is dominated by distance and minimisation, in which case we might be dealing with a biphasic defensive operation of symbolic character, rather than a complete lack of connection between lovers. Sexual arousal is indeed heightened by unfamiliar, distant and mystic attractions, but this may



not necessarily preclude the undercurrent of attachment—in fact, examining the phantasies of the object representation may have a lot to say about the nature of these psychosexual dynamics beyond pure instinctual organisation.

Eagle [41] noted that with regard to the transference dynamic, the more unresolved one's early attachment relationship, which is characteristic of insecure attachment, the more one will react to current partner as a stand-in for a parent, and the less able one will be to experience one's current partner as a sexual figure. *That one continues to be avoidant toward current partner strongly suggests that one is continuing to react defensively, as if one were experiencing current partner as rejecting and/or intrusive, similar to the way one experienced the early parental figure* [41].

Olivia's traumatic depression was reinforced by her dissociation, concealed by her substance misuse and further elaborated by her inability to invest her loving urges towards potential partners, because attachment was equated with death in fantasy. The same did not apply to her sexuality though, apart from her chronic anorgasmia, which was another symptom of her traumatic exposure.

During the final stages of treatment, we focused on creating a more coherent narrative of her traumatic past, developed a new template of object-relations where love would meet desire in a non-destructive manner characterised by integration of the two; while allowing her to build a more stable sense of self that inclined her to attempt something a bit more meaningful with her partner than raw sex.

Davies and Frawley [37] strongly endorse the therapeutic relationship for acting as a vehicle through, which 'soothing, undoing and redoing' of the traumatised client's life must finally occur largely based on the therapist's 'willingness to know' the person fully. The relational model composed of various psychoanalytic contributions emphasises the intersubjective dynamics between client and, important others as well as client and therapist, around interpersonal enactments stemming from the traumatic experience. Enactments are seen not only as essential but also as instrumental in helping clients process and make sense of the previously unconscious relational patterns that they find themselves in, their impact on self and others, and their perception and interpretation of others' words and behaviours.

## 5. Epilogue: *To love is to give what one does not have*

Studies of traumatised children have demonstrated unequivocally that infants and toddlers have the prerequisite emotional and cognitive capacities for trauma to have persisting effects on their psyche. Traumatized children can retain some type of internal representation of their trauma for years, as demonstrated through trauma-centric behavioural re-enactments, affective responses to traumatic triggers, expressive play, sensory and somatic symptoms, and even verbal recall [44].

Historically, a conception that has had wide currency within the psychodynamic school of thought is that psychological trauma in childhood both interrupts development and scars it forever. The overwhelming of the ego induced by psychological trauma is theorised to exert enduring memory imprints that cause intrusive flashbacks, emotional re-experiencing, traumatically driven behavioural re-enactments, trauma-centric fears, and disturbing dreams [20–26, 42].

The trauma is seen as having an enduring organisational influence on the client throughout the life span, a conception Gaensbauer and Jordan termed as a 'full-fledged' repetition. Analysing cases of traumatised adults and children, Herman ([24], p.32) concluded that *long after the trauma is past, traumatized people relive the event as though it were continually recurring in the present...the traumatic moment becomes encoded...and breaks spontaneously into consciousness, both as flashbacks during*

waking states and as traumatic nightmares during sleep [24, 44]. Olivia's traumatic depression lied in the early sexual trauma she was exposed to and although she did not have any recollections of being sexually abused herself, the enormity of the terror she witnessed damaged her developmental potential and the capacity to form healthy relationships driven by a constant battle between desire and affection towards an object that held oppositional qualities; a battle of gifting love driven by a lack of security. Lacan's famous aphorism on love was *loving is to give what one does not have*. For Lacan, this is the essence of loving—the key to love, to being able to love, is to accept one's lack: *One cannot love except by becoming a non-haver, even if one has* [45].

### **Conflict of interest**

The author declares no conflict of interest.

### **Author details**

Catherine Athanasiadou-Lewis  
Department of Psychology, London Metropolitan University, London, England

\*Address all correspondence to: [c.athanasiadoulewis@londonmet.ac.uk](mailto:c.athanasiadoulewis@londonmet.ac.uk)

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