

# Off the Couch

Contemporary Psychoanalytic Applications

Edited by | **Alessandra Lemma** and **Matthew Patrick**

A black leather sofa is positioned against a light-colored, textured wall. The sofa has a single cushion on the left side. The floor is made of light-colored wood.

SAMPLE  
CHAPTER

---

# Off the Couch

---

Contemporary psychoanalytic approaches

Edited by Alessandra Lemma and  
Matthew Patrick

 Routledge  
Taylor & Francis Group  
LONDON AND NEW YORK

First published 2010  
by Routledge  
27 Church Road, Hove, East Sussex BN3 2FA

Simultaneously published in the USA and Canada  
by Routledge  
270 Madison Avenue, New York, NY 10016

*Routledge is an imprint of the Taylor & Francis Group, an Informa business*

Copyright © 2010 selection and editorial matter, Alessandra Lemma and  
Matthew Patrick; individual chapters, the contributors

Typeset in Times by Garfield Morgan, Swansea, West Glamorgan  
Printed and bound in Great Britain by TJ International Ltd, Padstow,  
Cornwall  
Paperback cover design by Aubergine Creative Design

All rights reserved. No part of this book may be reprinted or reproduced or  
utilised in any form or by any electronic, mechanical, or other means, now  
known or hereafter invented, including photocopying and recording, or in  
any information storage or retrieval system, without permission in writing  
from the publishers.

This publication has been produced with paper manufactured to strict  
environmental standards and with pulp derived from sustainable forests.

*British Library Cataloguing in Publication Data*

A catalogue record for this book is available from the British Library

*Library of Congress Cataloging-in-Publication Data*

Off the couch : contemporary psychoanalytic approaches / edited by  
Alessandra Lemma and Matthew Patrick.

p. cm.

Includes bibliographical references and index.

ISBN 978-0-415-47614-0 (hardback) – ISBN 978-0-415-47615-7 (pbk.) 1.  
Mental health. 2. Psychoanalysis. I. Lemma, Alessandra. II. Patrick, Matthew,  
1960–

RA790.O34 2010

616.89'17–dc22

2009035638

ISBN: 978-0-415-47614-0 (hbk)

ISBN: 978-0-415-47615-7 (pbk)

---

# Contents

---

<i>Notes on contributors</i>	vii
<i>Foreword</i>	xii
<i>Acknowledgements</i>	xv
Introduction: contemporary psychoanalytic applications: development and its vicissitudes	1
ALESSANDRA LEMMA AND MATTHEW PATRICK	
1 Off the couch and round the conference table	15
JOHN, LORD ALDERDICE	
2 The shock of the real: psychoanalysis, modernity, survival	33
ANDREW COOPER AND JULIAN LOUSADA	
3 Suicide prevention: the contribution of psychoanalysis	46
STEPHEN BRIGGS	
4 Mothers and babies in prison: a psychoanalytic approach supporting attachment	66
TESSA BARADON AND MARY TARGET	
5 Observation, reflection and containment: a psychoanalytic approach to work with parents and children under five	82
MARGARET RUSTIN AND LOUISE EMANUEL	
6 Working with traumatised adolescents: a framework for intervention	98
ALESSANDRA LEMMA AND LINDA YOUNG	
7 Working with ambivalence: making psychotherapy more accessible to young black people	114
FRANK LOWE	

8	The relevance of applied psychoanalytic practice and thinking to the treatment of medically symptomatic patients	130
	JULIAN STERN	
9	Applied analytic work in forensic settings: the understanding and treatment of paedophilia	143
	HEATHER WOOD	
10	Panic Focused Psychodynamic Psychotherapy: a manualized, psychoanalytic approach to panic disorder	160
	ELIZABETH GRAF, BARBARA MILROD AND ANDREW ARONSON	
11	Psychiatry and psychoanalysis: a conceptual mapping	176
	DAVID BELL	
12	Cognitive behaviour therapy and psychoanalysis	194
	STIRLING MOOREY	
	<i>Index</i>	212

# Working with traumatised adolescents: a framework for intervention

*Alessandra Lemma and Linda Young*

---

Traumatic events do not discriminate: they cut across differences in age, gender, social class, religion and ethnicity. However, any one of these factors will also influence how a traumatic incident is experienced. In this chapter we will explore the specific effects a traumatic event can have when it occurs during adolescence. We will first outline a theoretical framework for understanding the impact of trauma on the mind and the particular import it may have when it takes place, or is being worked with, during the adolescent period. We will then describe a brief, psychoanalytically oriented intervention – the six session consultation model – that has been developed within the Trauma Unit of the Adolescent Directorate at the Tavistock and Portman NHS Foundation Trust.<sup>1</sup> Finally, we will offer some thoughts on the value of drawing on more than one theoretical framework in conceptualising the impact of trauma on the mind, and how to intervene.

### **The impact of trauma on the mind<sup>2</sup>**

It is well recognised by all clinicians, irrespective of theoretical orientation, that people vary in their responses to a traumatic event. For each individual, the event has a specific, personal, meaning. These idiosyncratic responses tell us something about the nature of people's inner worlds and the quality of their external and internal relationships. They also help us to understand why not everyone develops Post Traumatic Stress Disorder (PTSD) following a traumatic event.

Freud's (1920) early formulations about trauma were based on his observations of First World War survivors who had suffered 'shell shock'. He believed that the mind needed to protect itself from the intrusion of 'too much' reality and he described a mental shield, which acts as a kind of protective filter, allowing some material into the mind and preventing other stimulation from gaining access. The mental shield operates as a barrier not only to stimuli from the external world, but also to stimuli coming from different structures within the mind, distressing memories for example.

Freud emphasised that excessive stimulation was a threat to mental stability and is generally prevented from penetrating the shield. The shield thus acts as a skin for the mind, constantly filtering what can enter and what needs to be kept out of consciousness. If a major traumatic event occurs, however, the shield is ruptured; normal ego functioning is shattered and the mind is now at the mercy of unlimited stimuli. Category distinctions, such as past and present, are disrupted. Prior traumas, previously successfully contained in sealed off pockets within the mind, are reactivated, springing to life and binding with the current experience (Garland, 2002).

A distinctive contribution of an analytic approach to PTSD is its focus on the unconscious meaning of the event for a given individual. We understand that a traumatic event is invariably re-interpreted in the mind in terms of a relationship with an internalised 'other'. If we feel predominantly well supported internally by the relationships we carry inside ourselves, a traumatic event may well destabilise us temporarily, and we may even show signs of PTSD, but this is unlikely to develop into a more chronic PTSD response. If, however, at the time of the trauma we already feel unsupported within, irrespective of the nature of the traumatic event, we are more likely to ascribe agency to the event; there is a more or less greater conviction that it was caused, wished for or brought about by someone felt to be hateful and violent towards us. In other words, the external event (e.g. the car accident) is given meaning inside the mind in terms of a deeply personal, intimate relationship with a particular, affectively toned, representation of an 'other'. A young person who has been injured through an accident, for example, may experience his suffering as something 'bad' being done to him by a mother who means him harm. In this kind of scenario, we can discern how an internal sense of goodness and safety is lost and the young person is left with a feeling of despair that the world is no longer a secure place. A catastrophic event, then, does not exist objectively in its pure form, but is 'worked on' internally in a way that makes the experience specific and personal to that individual.

Response to trauma, however, also depends on external factors. People's responses are shaped by social relationships, as well as the broader contexts of their lives; for example, whether they live as a marginalised group by virtue of their ethnicity. External and internal realities operate dialectically, each impacting on the other in such a way as to construct an individual's identity. When external reality mirrors an internal catastrophe, and as well, when the internal scenario confirms an external disaster, then the chances of a severe traumatic injury are high (Lemma and Levy, 2004).

Traumatic events typically involve irreparable losses. There may be concrete losses such as the death of a loved one, or severe physical injury. There are also less tangible losses such as the loss of feeling, of hope, or of identity – the last of these is especially relevant when considering the impact of trauma in adolescence, a point to which we will return.

Traumatic loss is specific in being almost always associated with a life-threatening or horrific experience. Our experience is that it is harder to work through an experience of loss when actual violence has been perpetrated against the self. Often for both patient and therapist there is something especially difficult – unthinkable even – about interpersonal violence. Patients describe themselves as feeling, and indeed being, different from others. These changes are experienced less as loss than as some form of ‘marking’, which places the person outside normality (Lemma and Levy, 2004). This is particularly so when a young person is traumatised as they are especially vulnerable to feeling somehow ‘different’ to their peers. For example, one young man who had been stabbed could no longer take off his shirt in front of others (e.g. to go swimming) because he feared that the scars from the stab wounds literally set him apart from his peers, who would then judge him negatively. This marking or scarring, psychic and physical, trapped him, intruding into his mind and alerting him to his traumatic experience. Thus, the losses associated with the trauma arouse an experience of the event rather than memories of what is lost.

In the aftermath of a trauma, painful and disturbing images, thoughts and feelings cannot be held in the mind in a way that distinguishes them from the actual reality of the event; they cannot be contained as memories. Instead these thoughts and images become concrete, live flashbacks that typically intrude into consciousness as a literal re-experiencing of the event. A fundamental tension in working with survivors of trauma arises precisely because of this imperative to act rather than to think – a tendency that is in any case more pronounced amongst adolescents. At its core is the attempt to avoid psychic pain, associated with an awareness not only of loss but also of the destructive impulses aroused in the self in response to the trauma. For some individuals, as indeed for some groups and societies, hatred (in all its forms) frequently offers a retreat from suffering.

### **The impact of trauma in adolescence**

So far we have mainly been describing more general psychic processes that can be observed following a traumatic event. In working with a traumatised adolescent, rather than an adult, one is engaging with the impact of an event on a developing rather than a more or less developed personality structure. With this general point in mind, we now want to highlight four areas that have struck us as particularly pertinent to work with traumatised adolescents.

In writing about adolescents, it is important to clarify that we are not restricting this to a clearly defined age range; rather, we use it to refer to a phase of life that entails making the various transitions involved in the move from childhood contexts and preoccupations to those of adulthood,

such that the adolescent 'phase' can last well into the late twenties and indeed beyond.

### ***Identificatory processes and omnipotence post-trauma***

One common feature of adolescence, familiar maybe to parents, other relatives and teachers, is the adolescent's adoption of an omnipotent mode of thinking, feeling and behaving. Omnipotence is an important aid to managing the developmental tasks of adolescence; it assists the young person as they turn towards the external world, away from childhood family and friends and think 'how am I going to face this?', and helps manage the upheaval and instability in internal and external reality that characterises the teenage years. It is important, developmentally, for a young person to have the opportunity to experience themselves as at times in charge, to feel omnipotent and powerful, even if, in reality, they cannot always be so. It is this feeling which gradually becomes one of being able to be, and to feel, effective and be able to function independently in the world.

When an adolescent has experienced something traumatic, this characteristic need to feel powerful and in control is more urgent. The explanation for this lies in the way in which trauma destroys at least temporarily – maybe more permanently for some – a healthy growing confidence in being able to be potent and effective. The need to deny feelings of vulnerability and dependency may therefore be greatly enhanced following a trauma. This may also account for the difficulty we observe in engaging young people in therapeutic help after a traumatic event. Unlike the majority of adult patients referred to us who tend, on the whole, to take up the offer of an appointment once referred, quite a number of the young people referred fail several of their initial appointments. Whilst adolescents are notoriously harder to engage in therapy, we think that following a trauma, the young person may be sensitised in a very particular way to placing themselves in a situation that accentuates their awareness of their vulnerability and 'smallness' and the resistance to thinking about their experience is thus greater.

Freud (1920) wrote that a fundamental core of any experience of trauma is the sense of helplessness, and as we have been describing, the consequence of such an experience of overwhelming helplessness can be that the adolescent feels a powerful defensive need to regain control. One route by which this can be achieved is through particular kinds of identification.

It is well recognised that one of the major tasks of the adolescent period is identity formation (Erikson, 1968; Waddell, 1998). Adolescents try on for size different versions of themselves, some becoming more constant over time, others quickly dropped. Whatever forms of identification are taken up, in adolescence ordinarily identifications are in a state of flux.

In our work in the Trauma Unit we place special emphasis on understanding the nature of the *unconscious identifications* consequent to trauma.

In those young people who experience greater difficulty following a traumatic event this is typically because the event has precipitated a more destructive type of identification: we commonly observe that they identify, more or less consciously, and more or less rigidly, with the stance of victim or with the perpetrator, or both – the individual moving between taking up a version of one or other position. Whatever form it takes, this type of identification uses action, in this instance aggression, to replace thought and understanding. It reflects a collapse in the capacity for symbolic functioning (i.e. to represent an experience mentally rather than concretely), such that the ego's capacity to know about and think about the self – to reflect on the meaning of the trauma – is severely undermined. When mental processes cannot be conceived of symbolically, sensations, thoughts and feelings have a direct and often terrifying impact.

Such identifications can allow for some kind of resolution after a traumatic event, in that they unconsciously provide a way of taking control of and thereby defending against the pain of what has happened. Identification with the perpetrator, or aggressor, for example, allows control of the event and the feelings about it, through turning a passive experience into an active one. The abused child who goes on to abuse as an adult, through their own abusive behaviour, is able to push out of themselves, by forcing into someone else, the feelings of helplessness, terror and pain associated with the original traumatic experience.

This kind of identification with the aggressor is not uncommon following a traumatic event, but it carries a particular significance in a traumatised young person, because adolescence is a particular focus for identifications being tried out and sometimes fixed. Indeed, this is why if an adolescent turns to an identification with the aggressor it is powerfully charged, not only by the impact of the traumatic event itself but also by the developmental processes that are at play. Moreover, for the defence to be sustained this may require behaving in a way that does not just repeat, but surpasses in its violence the original traumatic event. This is often the case when the trauma is one experienced at the hands of another person rather than a trauma that is an 'accident' like a road traffic accident, or a natural disaster like a tsunami. An example might be the trauma of being the victim of a violent assault. Gang warfare in which you attack and/or attack back is not just a matter of revenge, but an intra-psychic requirement as a way of counteracting fear and vulnerability: you top the act done to you or one of your gang, or you 'cave in'.

As an alternative, paradoxically, the young person may collapse into the frightened state experienced during the trauma itself, staying in this state and withdrawing from the world and from life. This is the second common kind of identification we want to focus on, namely with being a victim. We say paradoxically because the emphasis so far has been on the adolescent need to avoid helplessness and vulnerability. However, the adolescent who at one

moment proclaims their omnipotence, at another is flooded with anxiety about the very same feeling of power, worried about their aggression and destructive impulses and about what they might do – an anxiety which can be defended against through remaining stuck in a victim position.

Identification with the victim can be the outcome for a young person for whom aggression and violence is a source of strong conflict, guilt and fear before the traumatic incident. This kind of conflict is an ordinary part of the adolescent process, but if strong may result in a retreat, following trauma, into a victim state of mind. If the young person cannot know about their own aggression and fears knowing about it, when such impulses *are* mobilised they may resort to denying this internal uprising because these impulses would otherwise become profoundly disturbing to the self. Staying a victim allows violence and aggression to be managed by being located outside the self, and in this way control is maintained, this time over destructive impulses. The world might then feel like a terrifying place, but culpability and guilt, which can be experienced as intolerable, can be avoided. Young people who experience some horrible assault and then put themselves in situations where it is likely to happen again, for example walking dark streets late at night alone in an unsafe area, are one such instance of this kind of identification.

By contrast with remaining locked into one or other extreme of identifying either with the aggressor or with the victim, many traumatised adolescents typically display mood swings, with an oscillation between murderous impulses – literally wanting to kill someone – and completely retreating away from the world – staying phobically shut inside the home. These can be the only options available to young people growing up in cultures of violence and crime.

### ***The significance of the body in adolescence***

We have been suggesting that a degree of conflict about aggressive impulses is quite normal during adolescence (Waddell, 1998). Physiological changes lead to increased sexual and aggressive drives, with the accompanying phantasies. The adolescent body is now able to have a baby or impregnate a woman, and is strong enough to do harm to another person. This adds to conflict about hostile or sexual wishes, as they can now be actualised. The extent to which the reality of the changing body can be successfully integrated into the young person's sense of themselves will depend on a variety of factors, including their particular individual character and, crucially, the extent to which earlier versions of these conflicts were managed, for instance in infancy and childhood.

All adolescents will struggle to some degree with the challenge of managing re-aroused and intense aggressive impulses and phantasies, but when the external world seems to confirm rather than contain fears and feelings, as

when a traumatic event occurs, the problem is compounded. In the context of a body that is physically strong, a violent phantasy can feel deeply threatening and unsettling. When something violent actually happens, and such impulses are aroused, the adolescent may struggle to contain the feelings and instead acts on them, feeling dangerously out of control.

Adolescence is characterised by a general tendency to project, to discharge and act out rather than think. An actual violent event offers a ready external receptacle or container for the projection of aggression, providing a solution to conflict and fear about aggressive impulses and the damage they might do. Such a solution is detrimental to development, however, as the personality is emptied out also of healthy aggression and consequently often of anything lively. Being able to be in contact with aggressive feelings and phantasies may become intolerable following a phantasied actualisation of their contents. This may result in phantasy itself becoming paralysed with, in consequence, a partial or more general freezing of psychic development.

There are other implications consequent on the physical significance of the body in adolescence when the trauma involves an actual physical injury or disfigurement. The changes of puberty are momentous; the body takes on a new and at times acutely painful significance as consciousness and self-consciousness of the physical self increases. At a time when body and sexual image are being reconstituted, but when any positive images about the self are very fragile, and feelings of sexual and physical potency so vulnerable to being damaged, actual injury to the body has an especially powerful adverse impact.

Other consequences follow from the obviously concrete nature of actual injury. As described earlier, trauma affects symbolic functioning so that it is in any event difficult to process what has happened, but this impact is particularly great when the traumatic experience has involved physical damage to the body and when there are physical scars. Getting on with life more or less successfully after a trauma requires, we would suggest, being able to process the events and their aftermath. When there is actual physical damage, trying to think about and represent what has happened symbolically runs up against the rock face of the actual concrete damage which perhaps cannot be repaired. Whilst this is true too in adulthood, the way in which adolescents are ordinarily so preoccupied with, and anxious about, their bodily selves significantly increases the impact of the damage. This is all the more so because the young person typically has less in the way of inner resources to psychically cope with the aftermath and adapt to this new damaged self.

### ***The significance of early childhood experiences***

As we have already suggested, from a psychoanalytic perspective we understand that throughout life any significant event, traumatic or otherwise,

reawakens the shadows of similar events that have gone before, which then have to be revisited. The shifting ground of adolescence in itself involves the re-emergence and revisiting of various childhood scenarios, which are worked over once more. Separation is an example. A young girl breaking up with her first boyfriend may display what seem to be disproportionately strong feelings of grief; but the loss of a boyfriend powerfully stirs up and re-creates earlier losses including those from the beginning of life. Traumatic events will, by definition, evoke and lock into previous 'bad' experiences, although they may be experiences that were not regarded as traumatic as such at the time. Indeed, the significance of trauma that has taken place in childhood may only emerge in adolescence.

### ***The role of the family and wider networks***

Most adolescents live within a family context. When they experience a trauma, their individual responses will be mediated to varying degrees by the responses to the trauma of those closest to them. The nature of the young person's early relationships with their parents will be important in influencing the extent to which it has been possible to internalise a capacity for containing experience. It is important to recognise though that in adolescence, as in childhood, there are actual parents and family and other significant adults whose responses to what has happened will enormously affect the response of the adolescent themselves.

Children and adolescents are very sensitive to their parents' reactions, both to the event itself and to talking about it afterwards. It is not uncommon that children will refrain from discussing a traumatic event and its consequences as they soon register that doing so upsets their parents. In our work we often find it helpful to meet with the parent(s) and sometimes with the whole family. The parents' capacity to support the young person is typically informed by the unconscious meaning that the traumatic event has for them. As we noted earlier, just as the young person's early experiences may be helpful in understanding their current response to a trauma, the parents may also find that the traumatic incident resonates in particular ways with their own early experiences, and this may get in the way of their capacity to help the young person make sense of what has happened to them. There may be traces or elements of early traumatic experiences which have never been fully assimilated. These traces can form more substantial deposits, which exist in encapsulated, enclosed parts of the mind, isolated from mainstream functioning. These experiences can be revisited and reawakened with considerable intensity and vigour consequent to a traumatic experience, not just in the young person, as we have been suggesting, but also in those closest to them.

Similarly, the young person's peers and teachers can play an important role in modulating or exacerbating their difficulties. For instance, in

relation to the kind of response given to the young person following a traumatic experience, ignoring that it has happened completely (carrying on as normal as if nothing has happened) or becoming overly intrusive or excited about the event are both unhelpful. At the same time some capacity to return to normality is often containing – an external reminder that the internal anxiety that the whole world has been turned topsy-turvy or collapsed is not the reality. Peers and other adults like teachers can be very helpful in this respect. Trusted adults in the young person's wider social network might also be important in being available and open to talking, if needed.

### **The six session model**

To understand the impact of trauma on a young person it is important to help them to find the words to tell their story, not only in terms of what has actually happened (i.e. the traumatic incident) but also in terms of the meaning they have given to that experience. We consider that intervention with young people who have been traumatised requires not only an understanding of the impact of trauma on the mind, but also a more particular appreciation, as outlined above, of how trauma impinges with particular force and poignancy during adolescence.

In the Adolescent Trauma Unit we have been offering a six session consultation to the vast majority of the young people referred to us. Although brief, for quite a number of the young people we see we have found that six sessions provide enough time to tell their story and to develop meaning out of events that typically, as we have seen, undermine the mind's capacity to reflect on lived experience. The process of elaborating a narrative about the traumatic event allows them to begin to manage the impact of the trauma. We have also found that six sessions, psychoanalytically informed, can help a number of young people in orienting them to the value of talking about the impact of the trauma and that this, in itself, marks the beginning of a process of making sense of their experience in a way that is containing and reduces the risk of acting out in destructive ways.

The process of consultation also enables the therapist to make a more accurate assessment of what further help the young person would benefit from. A proportion of the young people referred to us present with difficulties that are particularly complex, often because the index trauma is but one painful and disturbing event in a life marked by other traumas, losses and disruptions. We consider it important, therefore, to be able to offer a range of interventions, brief and longer term, including both psychoanalytic and cognitive-behavioural therapy.

The principal intention of the six sessions is to shift focus and understanding to the meaning and repercussions of the event. For some young

people, the event itself, however, may be dismissed. Our aim is to gently encourage *thinking* by opening up questions about personal meaning and identity post-trauma. Crucially, this exploration takes place in the context of the evolving relationship with the therapist, who will be sensitised to the way the young person's shifting unconscious identifications are played out in the transference. The therapist, however, does not make many, if any, transference interpretations, but makes very active use of their counter-transference to build a picture of the young person's internal world and to inform the way they intervene. Transference, therefore, is interpreted sparingly, but actively informs the therapist's understanding of the quality of internalised relationships and of how much the young person can bear to know at any given point. It is very important to monitor this because this is a brief intervention. We are careful not to disturb the young person's psychic equilibrium and to consider when and whether to challenge their defensive structures, which exist for good reasons.

## Case study

We will now illustrate some of the themes we have been discussing through two clinical examples.

Rob was 18 when he was referred to our service, two years after a serious road traffic accident. He was returning from a party, riding in the back of a car with three others, two friends from school and one of these friend's younger siblings. Two other, older friends, were in the front of the car. The accident which ensued, involving a car overtaking on a bend, was found to be the fault of the other car driver. In Rob's car, the driver, the front seat passenger and Rob survived. The three travelling in the back with Rob all died, two at the age of 16, the age Rob was at the time, and one aged 12.

Although the referral came some time after the accident itself, it was also when Rob had been due to travel to Italy for a year abroad before returning to go to university. On arriving at the airport, Rob had experienced an overwhelming panic which provoked him to give up his travel plans and to return to living at home, where he stayed as the youngest and only child of four now living there. The plans to go to university were suspended and Rob took up an IT job which he subsequently described as 'tedious'. His relationships with friends and a girlfriend also appeared rather empty and meaningless.

Rob presented as a slight, blonde-haired young man. He was attractive but looking younger than his years. In the first session he spoke very quietly and hesitantly such that the therapist had at times to strain to hear his words, and to anxiously think of things to say to keep things going. The therapist subsequently reported a sense of having to keep the session alive, whilst Rob himself was very quiet, hardly there, as if not wanting to make

too much noise, or take up too much space. He appeared to be retreating rather than engaging with the therapist and the session, which seemed a reflection of something pervasive now in his life.

As the first session progressed, it emerged that the two siblings who had been killed – aged 16 and 12 – were the only children of their parents. Rob described thinking of them and how sad it must be for their parents, now alone. It appeared that this was linked with Rob not being able to leave the country to go to Italy, that he could not bear the idea of leaving his parents without him, which he experienced as abandoning them like the parents of his dead friends.

In the second session, Rob was similarly quietly spoken and hesitant to begin with, but gradually began to talk more spontaneously, repeatedly commenting on how awful it was that his friends' lives had been cut so short. It was possible to link this with the way in which, in fact, Rob's own life had been cut short, because since the accident, he had not pursued plans that he had had and now led a life he found boring and unfulfilling. This could perhaps be understood as a response to his friends' deaths, which, together with the fact of his survival, left him too guilty to fully live his own life. Having addressed these ideas with Rob in the session, Rob then told the therapist that he had had a broken jaw and ankle from the accident and had been in hospital for six days. Whilst in hospital he had had lots of concerned visitors and people had made a fuss of him, bringing flowers and books. At the funerals, a seat was reserved for him at the front and people really took care of him. He vividly conveyed how horrible all this felt, how guilty he was about it, that a fuss was being made of him because of the accident whilst his friends were dead because of it.

Later in the consultation, Rob spoke more fully of his earlier childhood. He was the youngest of four children and had, as a young child, often resented being the littlest and therefore least capable and privileged, as it felt to him. However, he also rather liked being mum's 'baby' and did not like the attention the others demanded of her with their exams and girlfriends and teenage turbulence. Once the eldest could drive he would sometimes take the younger two out to the cinema or clubs. Rob at the time was younger than 10 and not taken along. On some occasions he would be at home with his mother on a Saturday evening and the time would near for the others to come back from an outing. He would find himself anxiously looking out of the kitchen window to see them coming, afraid, if they were at all late, that they may have been involved in some accident. It seemed evident in the consultation, as he spoke of this, that Rob knew at some level that this was a wish on his part related to his desire to keep his mother to himself. In the sessions Rob gradually recognised the particular dreadful significance for him of the death of his friends in the back of the car. He was the only one to survive, and this carried very powerfully the feeling of an actualisation of his childhood phantasy.

Freud (1915) writes of how mourning loss can become difficult under certain circumstances, perhaps particularly when the lost relationship was troubled or deeply ambivalent, leading to unbearable guilt when the relationship is actually severed. Under such circumstances the ego may be unable to mourn the loss and instead becomes identified with the lost – dead or damaged – object and a melancholic state results. This was relevant to the picture Rob presented. In addition, the reality of death crashing so violently into his young life badly damaged his growing confidence in himself in the world, and he resorted to a fearful retreat from life. This retreat also involved the projection of his own liveliness and aggression out into the world, which then was perceived by him as even more of a dangerous and risky place. The way in which aspects of his childhood experiences and relationships coloured the meaning for him of the trauma is perhaps evident; his guilt at surviving when his peers had died was magnified by the way this mirrored his childhood hostile, rivalrous and at times murderous impulses towards his sibling peers. Unconsciously then, he felt he was the murderer and he powerfully had to protect himself from this by becoming a victim himself.

Rob had the benefit of a close and loving family context; he had quite considerable inner resources that enabled him to use the consultation to think about these issues with the therapist, and to make use of the sessions and the good relationships he had externally (and which he had internalised) to move forward in his life again.

Other adolescents need more following the consultation. Molly, seen at the age of 19, described a history which conveyed an impoverished internal world which left her with relatively little in the way of resources that could enable her to think about and manage difficult experiences. When at age 11 she experienced a horrific car crash, which left her mother with permanent injuries, she managed this by evacuating the experience and any sense of her own need. Indeed, when she came for help it was not because of the car crash; she first spoke of it fleetingly during an interview and was prompted to come to the Trauma Service only on the advice of, and with considerable encouragement from, that interviewer, who thought she was vulnerable to difficulty as a result of the unresolved impact of the trauma.

Molly's parents had separated and divorced when she was very young. Her mother had subsequently had a number of boyfriends and it was one of these who was driving the car at the time of the crash. She described her relationship with her mother as always being difficult, saying that her mother was self centred and demanding. The therapist's countertransference, interestingly, was to feel rather unsympathetic and distant. Molly was also dismissive herself of her difficulties, which she talked of in terms of panic attacks and blushing, which tended to happen when in a group and aware of people looking at her. When she spoke of the accident, she did so without affect although describing a horrendous sequence of events;

describing, for example, her mother's head being wounded so deeply Molly could see inside.

After the accident, Molly experienced further disruption and loss. Because of her mother's injuries, Molly moved to live with a relative and their family. After initial difficulty, she settled in this new home and felt happy but at the age of 16 was moved back to live with her mother, in order now to be able to care for her. In many ways Molly was expected to be grown up, looking after her mother, with little attention to her own needs. The car crash and its horrific outcome amplified Molly's pre-existing experience both of her mother's needs as paramount, demanding and intrusive and of her mother not being a container for Molly's own needs.

Molly's attendance for the consultation sessions was sporadic and notably when she missed a session she typically did not telephone to cancel, leaving the therapist not knowing what was happening or whether Molly was going to return. This perhaps captured something of Molly's own childhood experience of instability, fear and uncertainty.

Her sporadic attendance also exemplifies difficulties that can often be evident in trying to engage the adolescent age group. She doesn't quite let go, but she also can't quite commit. As well as being a feature of work with adolescents, difficulties in managing a committed relationship are of central significance to Molly's presentation. In the first instance, she experienced the pain and loss of her parents' divorce. But additionally, she experienced her mother's subsequent relationships as damaging to her needs in that she felt her mother to be more interested in finding a new partner than in her. This internal, unconscious conviction of relationships as damaging was powerfully confirmed by the accident when it was her mother's boyfriend who was driving the car in which they were travelling, falling asleep at the wheel and then crashing, horrendously damaging both her and her mother. The trauma confirmed a pre-existing unconscious belief perhaps of the relationship between a couple as something catastrophic and therefore to be avoided. In the sessions nothing was said by Molly about relationships with young men, or women – she gave the impression of having none.

Molly herself had the notion that her anxiety and panic were not about the accident in itself, and although not articulating it in this form, it did appear that the core of her difficulties was rooted in problems with intimate relationships which had their origins in early childhood and infancy. Her panic related to a terror of being looked at, of being desired by others, particularly by a man, perhaps because of her fears of the disasters that follow, fears that had been so confirmed by the accident.

Although such ideas might find their place in the dialogue with Molly, her intermittent attendance mitigated against being able to explore fully and deepen the contact in the consultation. Missing sessions can seem an invitation to close a case, but often with adolescents titrated involvement is all that is manageable, especially following trauma. Molly, like many

adolescents coming to the service, could not use the consultation to move on. Nevertheless she made use of it to begin to explore, within the context of a therapeutic couple, aspects of herself and her life which she had not reflected on at all before. She was not able to commit to regular therapy, and hence intermittent therapy was offered. This is often an appropriate way of managing engagement with young people seeking help following trauma.

### **Concluding thoughts: the benefits of multi-modal services**

Our psychoanalytic focus on the *meaning* of the traumatic event is consistent with the dominant focus in cognitive-behavioural approaches for PTSD on understanding the idiosyncratic appraisals of the trauma and its consequences (Ehlers and Clark, 2000; Grey, 2007). The cognitive-behavioural approach to trauma aims to identify problematic appraisals during and post-trauma and to modify these. One important difference of a psychoanalytic approach is that it entails taking into account both conscious *and* unconscious meanings. In the Trauma Unit we now offer trauma-focussed cognitive-behavioural therapy as one of the treatments. The introduction of this modality alongside analytically oriented interventions has been an interesting and stimulating development for our service, and not just because trauma-focussed CBT is an effective intervention with some patients who present with intrusive symptoms. Rather, this development of our frameworks for intervention has allowed us to think about how these two therapeutic modalities can inform each other, and how they may be helpfully integrated in particular cases.

An important contribution of an analytic approach, we think, is that it attends, in careful detail, to the individual's internal world, which can then allow the therapist to develop a good grasp of the likely conscious and unconscious meaning of the trauma. We are suggesting that this *dynamic* formulation provides a very solid starting point not just for an analytic therapy, but also for trauma-focussed CBT interventions. Analytic approaches, however, have not traditionally been good at interdisciplinary dialogues and consequently have not always sought to integrate their dynamic conceptualisations about trauma with the emergent findings from cognitive science. By contrast, trauma-focussed CBT is grounded in an understanding of the functioning of traumatic memories. This grounding in the cognitive processes occurring during and in the aftermath of trauma has contributed to the development of effective techniques for helping the patient to elaborate the memory (and to relinquish defensive manoeuvres aimed at preventing memory elaboration) and so integrate the memory into the person's experience, thereby reducing intrusive symptoms. Although we are in the very early stages of this work, our initial impression from

experience is that integration of a dynamic formulation alongside the use of CBT techniques for helping the patient to process the trauma memory can, for some young people, provide a combination that is greater than the sum of its parts.

Research will be required to better understand which patients are most likely to benefit from which approach. In our experience, some of our young patients make better use of a CBT approach whilst others are not helped by it, but seem to derive more benefit from an analytic therapy. Irrespective of approach we remain impressed by the importance for any young person who comes to us following a traumatic experience of being in a relationship with an interested adult who strives to understand them, and who can bear to stay with some very uncomfortable feelings. Whilst this is true of any young person seeking help for emotional and psychological issues, this aspect seems particularly powerful following a traumatic event, as this so often undermines the young person's trust in other people's goodness and in their hope about the future. Perhaps this is one reason why even brief interventions can set in motion processes of psychic change. We have found that many of the young people we see respond positively to a brief intervention, often initiating impressive changes and challenging, of their own accord, some of the fears that took hold following the trauma.

## Notes

- 1 There is, of course, a wealth of literature on trauma (see, for example, Laub and Auerhahn, 1993; Van der Kolk and Fislser, 1994, 1995; Allen, 2001), but in this chapter we are limiting ourselves to describing the model of intervention we have developed.
- 2 This section draws on the work of Levy and Lemma (2004).

## References

- Allen, J. (2001) *Traumatic Relationships and Serious Mental Disorders*. Chichester: John Wiley
- Ehlers, A. and Clark, D. (2000) A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy*, 38: 319–345
- Erikson, E.H. (1968) *Identity: Youth and Crisis*. London: Faber and Faber
- Freud, S. (1915) Thoughts for the times on war and death. *SE* 14: 273. London: Hogarth
- Freud, S. (1920) Beyond the pleasure principle. In J. Strachey (ed.), *The Standard Edition of the Works of Sigmund Freud, XVIII*. London: Hogarth, pp. 1–64
- Garland, C. (2002) *Understanding Trauma: A Psychoanalytical Approach* (2nd enlarged edition). London: Karnac
- Grey, N. (2007) Posttraumatic stress disorder: treatment. In S. Lindsay and G. Powell (eds), *Handbook of Clinical Adult Psychology*. London: Routledge
- Laub, D. and Auerhahn, N.C. (1993) Knowing and not knowing massive psychic

- trauma: forms of traumatic memory. *International Journal of Psychoanalysis*, 74: 287–302
- Lemma, A. and Levy, S. (2004) The impact of trauma on the psyche: internal and external processes. In S. Levy and A. Lemma (eds), *The Perversion of Loss: Psychoanalytic Perspectives on Trauma*. London: Whurr
- Levy, S. and Lemma, A. (eds) (2004) *The Perversion of Loss: Psychoanalytic Perspectives on Trauma*. London: Whurr
- Van der Kolk, B.A. and Fislser, R.E. (1994) Childhood abuse and neglect and loss of self-regulation. *Bulletin of the Menninger Clinic*, 58: 145–168
- Van der Kolk, B.A. and Fislser, R.E. (1995) Dissociation and fragmentary nature of traumatic memories: overview and exploratory study. *Journal of Traumatic Stress*, 8: 505–525
- Waddell, M. (1998) *Inside Lives: Psychoanalysis and the Growth of the Personality*. London: Duckworth