Psychoanalysis
A New Overview

Edited by Floriana Irtelli, Barbara Marchesi and Federico Durbano

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Contributors
Peter Phiri, Isabel Clarke, Lydia Baxter, Naeem Farooq, Shanaya Rathod, Kathryn Elliot, Gertraud Diem-Wille, Valeria Corbella, Shelley Heusser, Linda Perez, Suzi Desmond, Cheryl J. Sundheim, Philippe Veysset, Floriana Irtelli, Federico Durbano, Barbara Marchesi

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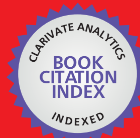

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Meet the editors

Floriana Irtelli is a psychoanalyst/psychotherapist and member of the International Association for Relational Psychoanalysis and Psychotherapy (IARPP) who has been lecturing for several years at the Catholic University of the Sacred Heart, Milan, Italy. She has worked at Fatebenefratelli Hospital in Milan performing research and clinical activities. She is among the authors of several books, including *A Fresh Look at Anxiety Disorders and Psychopathy - New Updates on an Old Phenomenon*, and has published articles for the *Journal of Affective Disorders, Research in Psychotherapy*, and the *Journal for Psychiatric and Mental Health Nursing*. She has participated in numerous conferences, seminars, and congresses. She is the sole author of the books *Illuminarsi di Ben-essere, Familiar-mente*, and *Contemporary Perspectives on Relational Wellness.*

Dr. Barbara Marchesi is a private practitioner in Milan, Italy. She received her degree in Psychology from the Cattolica University of Milan, after which she completed a specialty course in Adolescent and Adult Psychodynamic Psychotherapy. After working for almost ten years as a psychological consultant at Fatebenefratelli Hospital of Milan, where she completed a master's degree in Psychodiagnostics, she worked for five years at Papa Giovanni XXIII Hospital in Bergamo, where she completed the formation for Neuropsychology. Currently, she works as a psychological consultant in the Mental Health and Substance Abuse Department at ASST Melegnano e della Martesana.

Dr. Federico Durbano received a degree in Medicine with a specialization in Psychiatry. He has worked at various hospitals, including Milan "Ospedale Maggiore Policlinico," Treviglio, Melegnano, and Fatebenefratelli, where he achieved significant career milestones. He is currently the director of the Mental Health and Substance Abuse Department at ASST Melegnano e della Martesana. Dr. Durbano has had teaching assignments at the University of Milan (Nursing School) and the University of Castellanza (Master in Criminology). He has attended more than seventy local and national congresses and courses as an invited speaker and has published more than 180 papers. He is also a technical advisor to the court in the field of forensic psychiatry.

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Preface

This book provides a comprehensive overview of the contemporary evolution of psychoanalytic thought and significant developments in psychoanalytic methods, relating the dialogue with other scientific disciplines and different approaches. It also discusses the modern approach to psychoanalysis, psychoanalytic contributions to modern experience and culture, new empirical research derived from the practice of psychoanalysis, new perspectives, new psychoanalytic theories, and contemporary changes about the modern setting from Freud to the present day. Finally, this book provides updates about therapeutic trials and experimental methodologies.

Floriana Irtelli
Catholic University of the Sacred Hearth,
Psychology Department,
Milan, Italy

Barbara Marchesi and Federico Durbano
Mental Health and Substance Abuse Department in ASST Melegnano and Martesana,
Italy

Section 1

Contemporary Psychoanalytic Theories

Chapter 1

"How Can I Have my Cake and Eat it?" A Contemporary Dissociation-Based Self-State Model of Anorexia and Binge-Eating Disorder

Shelley Heusser

Abstract

The extant, contemporary psychoanalytic literature suggests that pathological dissociation is at the heart of most psychiatric disorders, ranging from personality disorders to affective and psychotic disorders. This chapter will begin by situating Janet's contributions to the splitting of consciousness, and then discuss dissociation, and the resultant splintering of the self, as a ubiquitous response to early relational trauma. Specific dissociated self-states as they appear in anorexia and binge-eating disorder will be put forward, using detailed clinical vignettes to describe the paradoxical functions of these self-states, and the way they structure the eating-disordered patient's relationship to food, eating, and their body. Treatment implications as they pertain to relational psychoanalytic technique will be considered.

Keywords: dissociation, Janet, self-states, anorexia, binge-eating, relational psychoanalysis

1. Introduction

The psychoanalytic paradigm shift from a classic drive model to a relational model as it emerged in the 1980s saw an upsurge of interest away from intrapsychic conflict to the way in which traumatic interpersonal experiences structure the developing mind. The move from a one-person psychology to a two-person constructivist psychology [1], along with developments in trauma and attachment theory, have thus seen contemporary psychoanalysis develop into a psychology of trauma that, after a century of practice informed by Freud's topographical model of the mind, [2] is finding its way back to his early research with Breuer into the splitting of consciousness [3]. In their studies on hysteria, Freud and Breuer documented their difficulties in the treatment of patients suffering the consequences of psychic trauma, and remained mystified by the role of hypnoid states in the genesis of hysterical symptoms at the turn of the 19th century. As a result of the relational turn in psychoanalysis, the 1980s saw a reintegration of dissociative phenomena, hypnoid states, and other identity disturbances into the theory and technique of contemporary psychoanalysis. Despite this progression, dissociation as a concept worthy of cementing itself into the psychoanalytic canon remains a work in progress.

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In this chapter, Janet's pioneering contributions into the splitting of consciousness will be examined. What contemporary relational psychoanalysts refer to as self-states, [4–6] Janet saw as unformulated, inaccessible systems of experience that are split off from the self and act as autonomous psychic entities [7]. As such, symptoms found in those with eating disorders represent revivifications of unthinkable parts of the self that remain unreachable and hypnoidally severed from normal perception and cognition. Using detailed clinical vignettes, dissociated self-state configurations will be discussed as they appear in patients with anorexia nervosa and binge-eating disorder. These self-states maintain the patient's intractable, pathological relation to food and eating in order to protect the self from disavowed experiences that are shameful, bad, or "not-me."

2. Janet on trauma and splitting

For Janet [8, 9], the origin of hysteria had its roots in the patient's "normal" consciousness being segregated from consciousness that is contained in the hypnoid state. This hypnoid state, carrying reminiscences of early psychic trauma, functions as an isolated island with its own actions, drives, perceptions, and feelings. Pathological changes in perception and consciousness, or dissociative symptoms, therefore occur as a result of an extraction process where trauma becomes unlinked from personal consciousness and remains alive and active in the symptom, or altered state of consciousness, that has now developed a mind of its own. The symptom, in Janet's dissociation model, is thus conceptualized as a split-off cluster of bodily-based feelings, sensations, perceptions, and actions, where dissociation is maintained by amnesia for the sequestered traumatic event.

Whereas Freud and Breuer's studies focused mainly on unbearable affect, and the conversion thereof into bodily symptomatology, Janet described a specific alteration in consciousness where the mind becomes split from the psyche-soma. In his research on psychological automatisms, Janet found that hysterical patients had a psychical weakness that narrowed their field of consciousness, so that certain phenomena would not be perceived or attended to. As a result, these phenomena developed independently and formed a second psychical system, the unconscious. The fixed ideas found in this unconscious were dissociated aspects of the self that had the tendency to re-emerge as automatisms, which hold the thoughts, feelings, and sensations that are not representable or accessible to the conscious self [10]. Nemiah ([11], p. 54) described these as,

"fantasies, memories, impulses and feelings [that are] unacceptable to the self, so frightening, saddening, painful or disgusting that they are forcefully excluded from conscious awareness … nonetheless capable … of producing derivative, ego-alien symptoms."

The narrowing of consciousness responsible for the psychical weakness postulated by Janet thus occurs when an idea, or a constellation of thoughts linked to a traumatic event, splinters off and takes on a life of its own outside of the nexus of the normal personality. These split-off pockets, or automatisms, are not accessible to each other nor can they be accessed voluntarily or consciously by the self. Symptoms can thus be seen as revivifications of dissociated parts of the self along with the traumatic reminiscences that are encysted within these parts. The ongoing process of relegating traumatic experiences to segregated parts of the self where they cannot be assimilated or symbolized linguistically forecloses the illusion of unitary selfhood and gives way to a fractured kaleidoscope of discontinuous self-states that are not authorized to exist in relation to one's overarching experience of "I" [12, 13]. In other words, the ability to integrate versions of oneself into a

cohesive sense of self – a self that gives the illusion of one – is impaired when there is a surplus of trauma-related vehement emotion [7, 14] and an associated narrowing of the field of consciousness, resulting in the dissociation of those versions of oneself from the main center of consciousness (the "I").

Under normal conditions, consciousness is a state of self-awareness where there is little or no impairment in the ability to remember experience that is linked to a specific self-state. In the absence of trauma, automatisms are bound together to the central self and "conjured up" voluntarily and willingly. Trauma, however, disrupts the self's capacity for symbolization and integration. As a result, inaccessible experience becomes encysted in a somnabulistic state that holds the fixed idea, [9] which is defined as a complex of emotional experiences, perceptions of self and other, and images related to the original traumata [15]. Symptoms, or automatisms, thus arise out of a somnabulistic state, the nucleus where the disavowed versions of self, along with their feelings, thoughts, and sensations, become entombed and remain active.

3. Dissociation in eating disorders

Janet clearly elucidated how uncommunicable, indigestable shards of a shattered childhood become hubs around which other psychological traumata cohere to become distinct self-states that make themselves known through dissociative symptomatology. For the purpose of this chapter, dissociation is thus understood as an attempt to prevent the flooding of the individual's current sense of "I" with other "Is" that are linked to historical experiences of relational trauma. These "Is" include affects, ideas, and sensations that are disavowed, due their intolerability, and their potential to threaten self-continuity. From this perspective, the symptoms that we consider anorectic or bulimic are seen as dissociative systems, sprouting from a mind that is home to multiple selves each with their own consciousness, their own truths, their own intentions, and their own relationship to food and the body [13, 15]. For the eating-disordered patient, the automatisms, more specifically, the acts of bingeing or starving, thus occur in an altered state of consciousness, the somnambulistic dimension, where the body becomes the stage onto which these dissociated complexes of mental life perform, communicate, and take control of the personality. Janet [9] used the word somnambulistic because it's as if the anorectic, in her altered state of consciousness, becomes hypnotized by her starvation, just as the binge-eater becomes hypnotized by her urge to devour. These trance states represent the cleft of amnesia that separates the individual's normal state of consciousness from another state of consciousness that now acts automatistically and independently under the instruction of the disowned self-state.

The disowned self-states, housing traumatic reminiscences, are therefore responsible for the binge, the purge, or the act of starvation in the eating-disordered patient. Inaccessible, unformulated, and disavowed, these distinct versions of self thus get enacted, and revivified, "through the body and bodily actions" ([16], p. 1). Their performative enactments on the body allow for the unspeakable to be spoken and the unthinkable to be acted out. Eating, in the binge state, or not eating, in the anorectic state, thus serves two purposes: 1) it happens without awareness, or in a state of narrowed consciousness, where the food stimulus diverts attention away from intolerable affect states such as rage, shame, and helplessness; and 2) it enables the patient to cross over into the split-off inaccessible self that is home to disowned longings and needs, or it enables the split-off self to intrude into the patient. For the binge eater who is in the grips of this split-off self-state, food is used as both a soothing ersatz-object for unmet needs, and a furious weapon that reinforces the organizing principle that such needs are too revolting, too big, and

too dangerous to be expressed relationally. The anorectic, under the spell of the restrictive self-state, experiences food and eating as a noxious reminder of instinctual impulses and corporeal drives that cannot be predicted or controlled, and so the contaminable, corruptible body-self becomes disavowed at deadly costs.

For the eating-disordered patient, what constitutes the kind of trauma that necessitates sequestration into dissociated, hidden pockets of the mind that find concrete expression through automaton self-states and the body? What happens for the infant's basic physiological needs, and their links to the psyche, to become eclipsed by the parent, so that the infant or child must fracture into distinct parts to secure some semblance of an "I"? More simply, what happens in the parent-infant dyad for the infant to sever its mind's link to the body and its needs? During infancy, all bodily instincts, impulses, needs, and drives are routed through the other. Hearing the infant's cries, the parent is interpellated by the infant's hunger to responds to, nourish, and regulate this bodily need. Should the ghosts from the parent's nursery [17] disrupt this process, schisms form in the infant's psyche that dislodge and relocate the unmetabolizable affects, sensations, and ideations of these early relational feeding experiences. Since these early experiences are dissociated, they are splintered off into parts of the brain where there is no codification, consolidation, and storage of memory. An optimal regulatory attachment system is thus contingent on the parent's ability to take up, digest, and rhythmically attune to [18] the infant's physiological needs, so that she can return them in such a way that the infant experiences them as tolerable, digestible, and safe enough to take in as part of *Me*. As a transformational object, [19] she imbues the infant's inchoate experiences with her own meaning. The spectral shards, or phantoms, of her own dissociated needs determine her ability to saturate the infant's budding experiences with meaning that is, upon its return, 'fit for consumption and digestion.' Her ability to act as a good enough transformational object is thus dependent on whether her needs, desires, and wants (i.e. her body) are representable to her mind as legitimate, recognizable, and worthy of being owned. Through repeated interactions with the ghosts of *the disowned* in the parent's mind, the infant experiences the containment of basic needs as an invasive ricochet of traumatic (indigestible) apparitions that entomb themselves as alien objects into the forsaken, unreachable pockets of its mind [20, 21]. For the anorectic, this alien object, which later morphs into the dissociated anorectic self-state, is related to an *active* dread of instinctual life and the embodied self, which keeps at bay other selves that seek to give expression to primal states of need, hunger, and desire which could not be routed through the parent. For the binge eater, this alien object, which takes on a life of its own as the bulimic self-state, is related to the dread of greed, wanting, and lust.

3.1 The anorectic self-state

Most patients with anorexia have a particular self-state arrangement where one or more self-states is organized around punishment and castigation of enjoyment, indulgence, pleasure, and excess. In the grips of this self-state, the anorexic feels like her appetite for life has been hijacked. It demands that refuge not be sought in the pleasures of the world, including food, but that it be sought in the comfort of abstinence, emptiness, and starvation. In her normal state of consciousness, the anorexic becomes a spectator to her act of starvation, performed over and over again behind a closed curtain that hides the utter dread of satiation and fullness. This is one of the fixed ideas [10] linked to the anorectic symptom: eating and nourishment are associated with the physiologic and psychic sensations, acts, and images of fullness and satiation, which must be controlled and dominated so that shame-filled states of need and hunger remain dissociated. Courtney, an adolescent

patient who will be discussed in the following vignette, refers to her monstrous anorectic self-state as Ursula. Named after the famous sea witch, she is a relentless slave-driver that squelches happiness and pleasure and makes Courtney question everything she does. "She makes everything so hard," Courtney tells me. "I'm always in two minds," she adds, giving me a glimpse of her splintered psyche by poignantly capturing the anorexic's split: on the one side, the mind of the scathing, critical torturer that demands strength and discipline, even in the face of death; and on the other, the crumbling, enfeebled self, squashed into a crevice of lifelessness that, under conditions of exhumation, would bleed vulnerability, need, and weakness. It is as a result of this dreaded exhumation of disavowed systems that Courtney clings to Ursula: "I'm scared that without her, what kind of person am *I* going to be?"

The anorectic self-state thus keeps the anorexic safe in the cage of its imprisonment, protecting her from the dangers that lurk in the world. As such, she is both cut off from the world and choked by it. Temptation becomes the anorexic's biggest fear. It shatters her illusion that appetite, and the need for human relatedness that go along with it, can be self-contained and insular. The experience of eating becomes tarnished by this abusive self-state. Food, which should be regarded as essential, sustaining, and inviting, becomes associated with the obscene, the bad, and the unwanted. While the anorexic remains in the dark (i.e. dissociated) from the life-threatening effects of this torment, she is also desperate to cling on to this anguish for the escape that it affords her. In consequence, she fears the intensity of temptation, the fluttering burn of desire, and the irrevocable havoc that would ensue should she surrender and forego abstinence. When she finds herself succumbing to food, in a different state of consciousness to the anorectic self-state, who is this person nourishing her, tasting, sensing, desiring? It does not feel like her, it is *not her*.

The abusive anorectic self-state does not merely command restraint and asceticism, it also orders the death of the part of her, the needy child, who hungers after human connection. It is this anorectic self-state, with its sniggering voice and deadly intentions, that steals the show and directs the play in such a manner that the hungry, starved, emaciated little girl remains famished, dissociated, and quarantined. The little girl is essentially trapped in a dead, lifeless body, entombed by her chronic lack of fullness. Calories represent flesh, fat, and appetite. It is this appetite, along with the temptation to cede, that needs to be warded off, destroyed, controlled, and suffocated. The body is stripped into consistency, the mind unhooked from the gut, the psyche severed from the soma [22]. In this segregation of the body from the mind, biological mechanisms such as menstruation and bowel movements appear as intrusive, ego-alien burdens that threaten to obliterate the anorexic's rigorous mastery over her own physiology. Moreover, physiological consequences of ingesting food force the anorexic to admit that she has a body; a body that can grow, impose, and take up space. The body exists in a war with her wish to prove that she has no needs, that she has no human hunger or thirst. The body, with its dangerous fleshiness and suspicious biological machinations, turns this wish on its head. Wary of the body, the anorectic self-state goes to great lengths to keep it in the dark; silent, and skeletal, not to be noticed, not to be spoken of. The fear for the anorexic therefore is not starvation. Starvation is her modus operandi, her survival. The real unconscious fear is that she will become aware of an instinctual underworld inside of her with specific versions of self that demand satiation and full-fill-ment. Thus, when the anorectic self-state looks into the mirror, she looks for the ghost that is successfully vanquishing the material self, cementing her ability to both destroy and protect: nothing goes in, and nothing comes out. There must be no needs, period.

Courtney

Courtney, an adolescent patient with a one-year history of anorexia, has been in analytic treatment for six months. As a result of the remission of her eating

problem, she is able to explore the splintered underworld beneath, or responsible, for her symptom. She describes her dilemma in this way:

"For such a long time, ever since I was little even, I built up this persona that I was bigger than I was, untouchable, and now it's broken, in pieces. And I don't even have a reason for that. I used to pride myself on being ok. It made me feel brave and strong."

"As if that's all there should be to you," I respond.

"I feel like I'm the baby these days, not my sister," she says, associating to the disowned part of her that is kept at bay by the anorectic self-state.

"There must be something so unwanted about that baby, and its needs."

"It's nothing I ever wanted to be ... weak and helpless. Sometimes I even feel physically sick."

As she tells me about her strict physical training regimen, she becomes aware of how she splits herself off from her body, willing it into subservience: no hunger, no pain, no needs. The purpose of the anorectic self-state is clear: total dissociation from instinctual life and embodiment.

"It should just be quiet," Courtney tells me of her body. "I'm always used to pushing through and never listening to my body. I forgot about my body." This dissociative "forgetting" about the body is at the core of the anorexic's dissociative organization, and the seemingly unbridgeable fissure between mind and body.

"I've never worked with my body, I've abused it, been against it."

I reply, "And now that it's forcing you to listen to it you may be feeling hateful towards it."

"It's not going along with me anymore," she decries. Once a target for Courtney's cruelty and abuse, her body-state [16] existed as a separate entity with a severed link to her mind and her overall self-experience. Now, there is betrayal and disruption, as her body emerges out of the amnestic shadows of her partitioned alien world, tentatively closing the chasm between psyche and soma. Where there was dissociation, there is now antagonism, or conflict, as Stern would say [4].

"I hate the fact that I am succumbing to it; it almost just happens now."
"Succumbing ... like an either-or battle; winner or loser," I reply.

"And it's hard because I'm sort of realizing it's not just a bad thing. When I was *one-minded* about things it was easier. That gap in between, I can't see it. It scares me."

Sometimes, Courtney and I will play with the word "suffering", a word that connotes a system of sensations, feelings, and thoughts that is anathema to her ongoing experience of herself.

"When you suffer you become a stranger to yourself," I tell her.

In my reverie, I start to wonder about an effortless, painless intermingling between Courtney's body and her mother's body during early nursing experiences. I wonder whether her mother was able to mold her body, her sensations, and her responses, to her infant's interpellations.

"I feel like if I was more like her I wouldn't be having these issues, which I'm not, which sometimes is annoying but other times I'm grateful. For me, experiencing each moment, or the details in the moment, is something she (mother) misses. She almost moves too quickly through life. And I'm not like that."

"It must be hard for you to know which side you want to be on," I say, as I point to the powerful identification that Courtney has with the part of her mother that is unable to stop, taste, and savor. "I shall not relish, and I shall not allow you to relish me, my milk ... life," is the message from her mother's unconscious enigma that may have been intromitted into Courtney's mind [23].

"Sometimes you really want to be in a moment but it's hard because there's also a very powerful force that takes you out of it."

"Yes," she confirms, "sometimes I appreciate these moments, especially lately, but it's also easier to remove it." She falls into a long silence, and I wonder whether we are in a moment, or in some kind of dead space.

This latter part of this vignette portrays the face of the kind of relational trauma that befalls the anorexic. We have to wonder about Courtney's mother's ability to attune to and "stay with the details" of her infant's cries, her hunger, her needs for embodied, *affected* soothing, touch, and regulation. Misattunement to these earliest of bodily needs, instincts, and drives, which could be defined as a kind of attunement determined by the parent's dissociation from her own enlivened stirrings, leads to intolerable affect in the infant that cannot be integrated into the mind where they form part of a coherent sense of "I"/"Me"; instead, instinctual life becomes extracted from body awareness and the functioning of the psyche-soma [22]; the sensations, ideas, and affects around these needs split off into discrete dissociated self-states that then take on lives of their own. Courtney's needs are housed in the parts of herself that are unrecognizable to her established anorectic persona, and when they break through, she feels bereft, confused, and anxious.

"I only have me and my army. I don't need people."

With this anorectic "army" self-state to protect her from her needs, the fragile parts of her become the "enemy to be extinguished."

"The struggling is *not me* … something I hide deep down hoping that no one will ever find. It's who I am but I can't *live* with who I am."

I repeatedly empathize with her dilemma: "It's hard to break free and explore these struggling parts. If you did, you wouldn't be able to *live* with it, and another part of you would perhaps even punish you for it." At other times, I frame her psychic impasse in this way, "There's a constant battle between defending the army, and looking at the damage she's done".

"I start *eating myself u*p about it," she tells me. She describes the anorectic army self, at once her protector and destroyer, as "the person I wish I was if I wasn't human. I can't negotiate with her. In a way she just wants what's best for me, to try my hardest, to have no excuses, I just can't live up to that."

Courtney wonders whether her "mind" will ever allow her to be happy. I tell her that Ursula, the slave-driving army sergeant, and her would have to get along. "That won't happen, because then I'd have to acknowledge that she's *me*, or *in me*. I've got myself hurting me! It's like an abusive relationship, the weaker you are the stronger the other part gets and it just thrives."

We circle over and over again around the theme of Courtney's abuser self being both the defensive scaffolding that protects against intolerable, indigestible not-me states, [24] and the torturer that paradoxically ensures life, and death, at its own hands, and no one else's. "Ursula is the one keeping me alive," Courtney tells me, "without her drive I would have killed myself a long time ago."

"You're at a loss," I tell her, "How do you get rid of something that is your skeleton, your structure, your army, but that also haunts you mercilessly on the inside."

It is this skeleton, her trusted, faithful military operator, who vitiates the human inside of her.

"I'm human, I wish I wasn't," she tells me. "Being human … you can't control everything."

"Like if you can't control something, you'd find something underneath, like a want?"

"I felt bad for being admitted to the clinic. If I take off the pressure, where do I go, where does that leave me? I don't want to be that kind of person. Even when I fell apart I kept on pushing."

"Falling apart means you're not able to cope, which is a no-go," I echo.

"It's like food. I shouldn't want the nice things. I don't deserve it. I've set such rigid boundaries for myself and I don't want to take these away because if I do I don't know what I'll be left with."

"It's frightening, and it's also frightening to know that the parts of you that want and need things have other ways of reminding you that they are there."

"But I don't want that," she avows, before she takes a tentative step to stand in the space [5] between her budding desire, and the disavowal thereof. "I actually don't know what I want. I've been pushing away the parts of me that want and need for so long. I allow myself to relax for one day and my mind goes wild and aflurry with anxiety and panic."

In the next sessions, Courtney expands on the anorexic's self-imposed exile from the human, fleshy realm that demands interconnectedness and dependency. Again, she stresses the importance of the anorectic self-state in segregating her from experiences that seem anathema and alien to her overall sense of "I".

"I don't like putting my stuff on other people. It doesn't make sense in my mind."

I reflect her dilemma in the transference, "It seems so foreign that you could lay something on someone and have them carry it for you." As I say these words, I feel anxious and alarmed. Courtney and I, suspended in the forbidden affect storm that is swirling between us.

"You just had a thought and it feels scary to share it." She nods, "My chest feels so heavy ... tight."

"Like something wants to come out but it's being restricted?"

"Maybe," Courtney looks uncomfortable, struggling to take in the connection between the restrictive anorectic symptom, or self-state, and its necessity in restraining unregulatable affect related to *our* connection [13].

A few minutes go by.

"It's my baggage, that's where it ends," she tells me, too calmly. Where is Ursula in this exchange, I wonder to myself.

"Speaking to someone makes it real," I venture.

"Yes."

I continue, "That there's another person, another body, and that doesn't compute. It shouldn't be like that."

"I've been having a persistent thought. I want to feel the pain, I want to feel it. I feel so lost and if I just ... physical pain will make me feel human again."

Something is broiling underneath her anesthetized shell. Courtney wants to feel something. A tendril of pain at her own hands, as opposed to the ferocious unstitching of the suture that would ensue if she felt *with* someone.

"Without the pain you'd feel too dead."

"Too dead to die," she responds, as she invites herself further to think about the function of her anorectic self-state. "She stopping me from things and that is destroying me because I'm floating around like a ghost. I'm not living like I want to."

I share with her my association to The Living Dead. "I want to live and thrive," says one-self-state; "it doesn't seem like an option," says another self-state.

"The idea that something could sprout inside of you seems unimaginable."

In the next session, Courtney tells me about a picture she drew during an amnestic episode of daydreaming. It's a drawing of two people in one body. A woman, peaceful, serene, plain, with wild hair, and inside of her, a screaming sprout (child); dark, shaded, and open-mouthed, her eyes squeezed shut in pain. "She's scared," she tells me of this child. "Is she hungry?" I ask tentatively. Courtney tells me that in one sense, the girl is not hungry for life, "she's done". In another sense, this girl has starved herself of the joys of living, "unable to taste any of it", and "too exhausted to *want* it anymore." "It's almost like not wanting a future is easier. Wanting one I'll have to fight for it," she adds.

"If you want a future you will have to fight this raging screaming girl on the inside who will destroy you if you keep ignoring her."

Courtney feels heard, "I almost walk over that part of me, and that then ends up making me not okay. Lately, through my panic attacks, I've been seeing how strong that part of me is and its making itself more known."

"If she doesn't she'll go under and keep raging from the basement," I tell her.

"Last week I gave myself two days of me-time. It's like painting a new picture from scratch. Something I don't know." "Yeah," I respond, "and I imagine if you spent too much time there you'd become unrecognizable to yourself.

In this vignette, Courtney has located one of the dissociated selves that has been splintered off from her consciousness by the anorectic self-state. It's a child self-state that is in pain, frustrated and raging, in desperate need of safety, care, and holding. This version of Courtney shrieks, agape and hungry, from the cauldron of her interior, pounding her consciousness through panic attacks and anxiety with remnants, or reminiscences, of torturous, unmetabolizable desire.

Kelly

Kelly, a patient in her 40s who'd been battling severe anorexia since late adolescence, shared a dream just before she abruptly terminated therapy. She is with her mother and her father in her childhood home,

"My father's heart stops beating. I shake him, he takes a breath, and comes back to life. I'm relieved, but he's aged by twenty years. He looks like a dead person. My mom is just watching. He starts vomiting uncontrollably and having diarrhea. Everywhere. I think what if the cancer is back. I try to carry him to the bathroom. My little nieces and nephews keep getting in the way. I'm trying to explain to them that grandad is sick and I really need to get him to the bath. As I lay him down he starts bleeding. It starts spurting everywhere. He keeps apologizing, saying it's disgusting. I tell him not to worry about it. I just need to get him to a bed."

There are multiple ways in which this dream could be understood, but from a dissociative self-state model it, it expresses the cavernous split between Kelly's psyche and soma. There is Kelly, in her normal state of consciousness (i.e. her usual sense of "I"), and her split-off body, projected into her father. As a result of this split, she can safely experience herself dying. Many professionals struggle to comprehend the anorexic's lack of alarm, even nonchalance, in the face of their impending death. It is because their body does not belong to them. The anorectic self-state is there to ensure that things get held in; it's a safeguard against the hemorrhaging that would occur if she spontaneously gave over to abandon. If it was not for the anorectic self-state, Kelly would have to find a way to *be* in her body. The terror of the out-of-control body would obliterate her mind, in the same way that her mother was too abolished, or frozen, to contain and mentalize her infant's evacuative bodily functions. Her mother could not revel in the richness of her infant daughter's body-state, instead, she was either repulsed by it, frozen, or driven to resist it by strangulating the body of its impulsiveness, its freedom, its naturalness. The dream is thus about the way in which the anorectic self-state revivifies and reenacts this infantile trauma, Kelly suffocating her body, and its evacuative richness (bleeding, defecating, vomiting) through starvation. I imagine the opposite of keeping the body in check in this way would be a kind of pouring, a spurting, a gushing. "What if I unleash a part of me that doesn't have a limit?" Kelly once asked me. This dream is also about the potential unleashing of banished child selves, as represented by the nieces and nephews. These dissociated selves, with their infantile longings for care, nurturance, and freedom, will not surrender to death without a fight. They keep getting in the way of the anorectic self-state's death grip until they can emerge from the shell of dissociation. Unfortunately, Kelly left therapy before we could move out of the specular dimension and "get in bed together"; in bed with her and all her

dissociated selves. Just as Kelly in the dream, I became the one watching the patient die before my eyes, veering between momentary spurts of life and protracted states of lifelessness, keeping vigil over the tightening hold of her anorectic self and its repeated efforts to block her ordered rhythm from becoming a shared rhythm. Had she come back, I may have said something like this, "You're coming to life through this dream, and I hope that this violent part of you lets you live long enough that we can make use of this." With this interpretation I would have communicated to Kelly that her dream serves as the vehicle through which she, the dreamer, is awakening [25] and coming into her body, while also emphasizing that the resuscitation of this emergent dreaming self is under threat of the anorectic self-state's deadly grip on imagination and corporeality.

In the next section of this chapter, there will be a discussion of the dissociative configuration of the binge-eater's psyche. In the anorectic self-state, the self has no corporeality, there is total power over the self, which has been rid of its link to the body. As the commanding authority over the anorexic's mind, the anorectic self-state leaves the patient unencumbered by the exigencies and stirrings of instinctual life, narrowing attention away from the flesh and away from the body. The binge-eater's self, however, is not severed from her body, instead, the binge-eater lives in conflict with her body and its needs. Where anorexia is about the refusal of flesh, the binge acknowledges the body graphically: it hungers, it takes in, it rejects, it wants again [26]. The binge-eater's need for food and nourishment gets associated with greed and excess; so disgusting and terrifying is this need that it gets pinned to a separate part of the binge-eater's self, the bulimic self-state.

3.2 The bulimic self-state

When the haunted self of the anorexic succumbs to food, it's seen as an admission of weakness and a desire for life's pleasure [26]; when the corporeal self of the binge-eater succumbs to food, it's seen as an admission of greed and a desire for more. In anorexia, there is no needing at all; for the binge eater, needing is disavowed until it erupts furiously through the bulimic self-state. It is this self-state that holds the binge-eater's dissociated desire and passion.

As a result of the binge-eater's lack of compassion for her needs, the fleshy body gets violently assaulted through junk food. In the binge, it is not the individual that demands the food, it is the body-as-dissociated-thing that objects to moderation and control. The fear for the binge-eater is of there being no restriction, of wanton hunger introducing itself in all its foreignness and vulgarity. She cannot bear the shame, and the fear, of wanting. This is not say that she lacks parts within her self-organization that are not fascinated and seduced by the voluptuousness of the body. These inquisitive, needy parts get stifled by the binge-eater's normal self, whose enforced restrictions (e.g. diets, eating plans) attempt to still the clattering rumblings of excess that could spew from these curious, wanting selves.

For the binge-eater, food thus signifies an invitation to be seen by the self and others as wanting. It must be warded off in its sickening badness. Food is whining greed, and its intake must be controlled and regulated with vigilance. The bingeing self holds the "eeew factor" [27] in relation to the body: I am too much, too big. It is a self-state that is associated with ferocious wanting and voracious hunger in its rawest form, a yielding to appetites and loss of control which the normal self perceives as uncontrollable and bad. The surrender to food is an admission of bad neediness and a crude statement that the binge-eater's body is also incarnated as a fleshy, sexual, corpus replete with verve and lust [28, 29].

For the binge eater, infantile experiences around appetite, need, and wanting could not be regulated or recognized by the caregiver, and thus were encoded as

affectively threatening, unbearable, and overwhelming, so that they became frozen into a dissociated self-state that then took on "an imperious life of its own" ([13], p. 903). As Janet's theory of the processing of traumatic experiences posited, knowledge, body sensations, and feelings around that which is intolerable are not forgotten, they live in frozen, fixed states alongside other configurations of consciousness, occasionally, sometimes violently, finding expression through food and the body. Thus, when the binge-eater binges, it's as though her greed has suddenly catapulted her into her body from a recess of her mind very alien to her; and when this greed leaves her, her body feels like a dump, something immensely shameful and heavy and disgusting that she now lugs around with its excess heft and insufferable rapacity.

Romy

Romy, a patient with a binge-eating problem, who had just exited an abusive relationship, spoke of her inability to allow anyone to comfort her, adding, "I give so easily but I ask for nothing."

"The binger in you has to steal her comfort, she knows you won't give it to yourself," I tell her.

Romy tells me that her unconscious turns into Freddy Krueger while she's asleep. She uses this image to describe the revivifications of the horrors that are entombed in her mind; horrors that are forgotten, but find resuscitation during altered states of consciousness. As in Nightmare on Elm Street (1984), these echoes of tortured pain molest her mind and body during hypnoid states, unable to be pulled into the waking world where these phantoms can exist with the rest of her self-configuration. Just as Freddy Krueger represents the fear of an unseen threat, so the binge signifies the threat of monstrous greed and gory food-lust. This is the "unthought known" that Bollas speaks of, [19] haunting the binge-eater in this altered state of consciousness. Through the image of Freddy Krueger, she perceives the uncanny within the monster that is her bulimic self. The binge is thus driven by an ominous Freddy-like presence, the dissociated bulimic self, lurking in the shadows of the patient's subterranean world (psyche) that, in a dream state (i.e. dissociated or hypnoid state) ravages the body. In this hypnoid Freddy Kreuger binge-state, Romy remains dissociated from the damage that this "rummaging" self-state inflicts upon her. "Rummaging" depicts the burrowing frenzy and chaotic disorderliness typical of her experience of herself during the binge. She eats as if she'd never seen food before. Only afterwards does Romy sit with the effects of this ""bad nightmare", consoled, though, by that "comfortable lethargic feeling" that comforts her and lulls her to sleep. For the binge-eater, the fear is not merely around being overtaken by greed, the fear is also of emptiness, the indescribable state of hollow longing and barrenness that lies on the other side of greed.

Kirstie

Kirstie beautifully describes the dissociative, hypnoid mechanisms underlying her binge states:

"You feel like you've been defeated. You don't have any intention or want to do it, but then physically you see it, you feel it. It angers me in a way because the rest of the day I'm angry that I couldn't control it or stop it. It's like you enter tunnel vision, and you lose ten minutes of your life."

What angers Kirstie here is that her need to stay on top of things, representative of her deeper need to "schedule" her urges, wants, and desires, gets thrown off by the binge. For Kirstie, who plans meticulously when and how to be intimate with her husband, the binge is the thing that she cannot stop in its tracks, it's the thing she does not see coming, it's the thing that announces itself unplanned. Most importantly, she says, "it's the thing that keeps coming back." She uses the word "overpower" to explain how the fixed idea around food first dominates and then explodes into her mind. This bulimic self-state demands to be fattened up with the

doughy sugariness and starchy goodness that she deprives herself of in non-hypnoid states of consciousness. Her body commands the sweet nourishment which her mind denies her. At family gatherings she never dishes dessert: "Everybody would look at me," she tells me, "it's such a negative connotation." Here, she is inviting me to look at the part of herself that would feel phantom-like, searing pangs of shame if she caught herself indulging, wanting, *treating*. This is the binge-eater's not-me self, [24] with its unspeakable needs, longings, and desires, that got banished to the dissociative realm. This self carries those hungers and cravings for human relatedness which could not find containment or digestion through her mother, due to the shame, self-loathing, and deprivation around her own oral needs. "My mother has forever been on a diet," Kirstie avers.

It should not be surprising that Kirstie's binge-eating happens on-the-go. As with Romy, the "Who" that binges does so in hiding. For this part of the patient, food, which stands for nurturance, comfort, and care, needs to be stolen, rummaged through, and devoured clandestinely. It's not just the comfort and the goodness that is disavowed, it's the uncontrollable nature of an impulse that is even more dreaded; the fact that something measured and planned could turn into something lustful, unrestrained, and wanton. The nameless dread [30] is that deprivation could turn into gusto, and that gusto could turn into enthusiasm for human relatedness.

The planning that goes into Kirstie's prepared meals evaporates at the attack of the binge, "one strike that ruffles everything," she declares in dismay. "That one messy binge really has the power to shake things up for you," I tell her. Is Kirstie resisting the food that she prepared, or the version of herself that went into the planning of the food – a premeditating, depriving, scrupulous self? "The fear is that this thing won't stop," she tells me. "That there is this part of you that you can't catch? This part that creeps up on you and then blasts 'I'm here'?" I say. "The uncontrollable side," she utters, "I hate myself for that." Where the anorectic has no sense of what could bring her body to life, the binge eater is aware of what titillates her, but deprives herself of this due to the fear of greed. She shifts between states of wanting and rejecting, thus regulating food in the same way that she regulates her desires. Deprivation puts her at risk, as it increases the voltage with which her disowned selves, the greedy, needy, thirsty parts, flood her consciousness.

As seen in these case vignettes, binge eaters often use images of monsters or animals to describe their bulimic self-state. These images signify the split between worlds, where needs that are considered universally human become connoted as too primal, monstrous, and other to exist inside of them. Simply physiological urges to indulge in, for instance, sweet treats, or to give in to passionate love-making, are disavowed in their categorical not-me-ness. These unintegrated aspects of self get enacted with food [16]. It's as if the binge eater were saying: "Were I to pander to my needs and urges, the good, conscientious, vigilant *me* would cease to exist. I'd get stuck in the festering badness of indulgence, which is *not me*. I know I'm hurting *me* by depriving myself, but I'm afraid that if I taste something else, something more, I'll never let it go."

Ali

Ali, whose father chose alcohol over his family, and whose housewife mother resented her passivity and dependence on her husband, had structured her self-configuration around the organizing principle that she would never need or ask for anything. In her association to the word indulgence, she spoke of an "unnecessary state of selfishness and excess", even using the word "gluttony" to describe the disastrous consequences of heeding one's wants and desires. As the wanting and needing self is disavowed, it can only find expression through the dissociated bulimic self-state. To protect herself from this self-state, she buttresses the version of herself that is founded on refusal, discipline, and restriction. She bans herself from going to the grocery store, hires a coach, logs every meal into a calorie

tracker, and refuses her daughter's cookies that were made for the school bake sale. This is the problem-solving conqueror inside of Ali who experiences a "high" over mastering the urge to binge. "I've got this down," she professes proudly. Permission becomes the punishable offense. As the line between permission and indulgence breaks down, she finds herself in the wreckage of swimming in the abyss of her bodily cravings. In this abyss, it feels like she is drowning, the body holding the unmet, disowned needs engulfing her like the wave that rips at the person lost at sea. Ali uses the image of the wolf to describe this engulfing bulimic self-state. In the epicenter of this volcanic abyss, the wolf becomes insatiable: "What more do you want, I'm already giving you what you want," she laments as she reflects on her experience during a binge. The compulsive monster-wolf prefers crunchy food; the sound, the sensations, and the biting regulate terrifying states of anger and frustration that would overwhelm her if her consciousness were not narrowed in on the food. In this state, she cannot afford herself the time to sit and eat slowly. Instead, food is guzzled, as if the wolf's survival depends on it. "Don't think you can deprive me any more," the wolf might be saying. This wolf cannot chew. He devours, he attacks. He gives in to impulse without inhibition or restraint, something Ali cannot fathom doing in her normal state of consciousness. It is in this primal state that she dislodges herself from her emotions. "This is not a nurturing state," she says, "it's not a dainty reach for a biscuit." In this attack, there is a level of aggression that is only accessible to her through the wolf. Why is it so hard for her to nurture herself? This is the purpose of the bulimic self-state, a violent assault on the person for harboring disowned wishes for non-food-related (i.e. human) nurturance and connection. The bulimic self is there to prove to the binge eater over and over again that no good comes of giving in to desire or want. The binge is "a happy birthday to me from me," as Ali aptly put it; a foolproof strategy of one's self-sufficiency, on the one hand, and a glaringly shameful reminder that one's needs are too big to be digested with, and through, an Other.

4. Treatment implications

Psychoanalytic treatment of the anorexic and the binge-eater occurs in conditions that take seriously the multiplicity of the self. The analyst accepts that the treatment will become the meeting place for her patient's dissociated selves. She knows that her patients do not have the ability to dream up their bodies in their minds, and that she will become the portal through which her patients begin to associate to their bodies. Her patients will eventually route their disowned needs and longings through her, but before this happens, she will analyze, over and over again, the reasons behind the anorectic self-state's erosion of her patient's body, and the purpose behind the bulimic self-state's rerouting of desire away from the patient's self. She may use language around food, eating, and bodily function to achieve this, elaborating the inscriptions made upon her patients' bodies by violent, yet protective, self-states. She will respect the autonomy of the anorectic and bulimic self-state, working painstakingly, at times against the odds of life, to discover the versions of truth contained within these states [12, 13, 15]. She will have to pay particular attention to the way in which her body becomes the vehicle through which uncommunicable shards of her patients' lives tussle for expression and articulation. Her bodily reactions, her dissociations, and the self-states inside of her that get called on by her patient at any given moment, will give her clues to her patients' unformulated bodily and affective itchings. She will also take note of when, and how, her patients become ruptured by their increasing body awareness and the emerging needs that had been dissociatively demoted to angry, lost,

unknown child selves. Sometimes these ruptures will occur in the treatment dyad, with the phantoms, or ghosts, carried by these child self-states clamoring for air time. Through enactments, the analyst will express the traumatic reminiscences of the unthinkable and the 'unfeelable' (unfillable), first to herself, and then to her patient, in the here and now. Every time the patient senses that the tendrils of connection to her analyst are deepening, it will feel like she has committed an unforgiveable violation, a violation which the anorectic or bulimic self-state will remedy through attack on the body. The pain, the restriction, the deadness, the hunger, the disgust, the shame, the forbidden lust, the dread of too much – all the affects that fuel the splintering of the patient's self – will play out between her and her patient, so that ultimately she learns to live with her disowned parts in a state of mutual antagonism; with more tolerance, and less dissociation.

5. Conclusion

Multiple psychoanalytic theories have been proposed in the genesis of eating disorders, ranging from drive-conflict models to ego psychology and object relations theories. This chapter attempts to enrich the psychoanalytic conceptualizations of eating disorders by examining the dissociative structures that may underpin the eating-disordered individual's behavior. Consequently, there has been a description of Janet's pioneering ideas into the splitting of consciousness, where the automatism, or the symptom contained within a particular self-state, actively maintains separation between parts of the self that cannot be formulated, integrated, or held in tension. Through an extended, detailed clinical vignette, it has been demonstrated how the anorectic self-state entrenches the anorexic's conviction that her embodied, corporeal self does not exist. As a result of this defensive disembodiment, she can walk alongside her corporeal self, as opposed to it being her, and teeter comfortably on the edges of death and bodily annihilation. The bulimic self-state, on the other hand, holds the binge-eater's greed, desire, and lust. Wanting and needing, intolerable states which were denied a spot in the assembly room of the binge-eater's mind, are relegated to monster or animal selves that, in titrated states of consciousness, express the insatiability and ravenous passion that remains unsymbolized and unformulated. Treatment considerations have been outlined for clinicians working from a contemporary relational psychoanalytic perspective, highlighting the inevitability of enactments in the intersubjective space in revivifying traumatic reminiscences that are kept at bay by particular self-states, and stretching the limits for mutual regulation of intolerable affect.

Author details

Shelley Heusser
Private Practice, Johannesburg, South Africa

*Address all correspondence to: psychology@shelleyheusser.co.za

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Chapter 2

The Real Self and the Ideal Self

Floriana Irtelli, Federico Durbano and Barbara Marchesi

Abstract

Every human psychic aspect, even the development of the Self, cannot be considered separately from the financial and cultural context in which it is inserted: as a matter of fact the realization of individual freedom is correlated to broader economic and social changes, which influence the individual on self-realization. In the chapter, various theories about this topic and about the ideal self are explored, and it concludes by considering that self expression helps people to satisfy their real emotions and their real self, it also highlights the fact that self-realization and self-expression are among the highest needs on the human needs scale, and they affect human health.

Keywords: ideal self, real self, psychoanalysis, health, culture, society, finance

1. Introduction

Every human psychic aspect cannot be considered separately from the financial and cultural context in which it is embedded. Adopting this perspective, it appears evident that the realization of individual freedom must be closely related to wider economic and social changes, which influence the individual about the realization of his own self, and probably also about his awareness development. Our reflection starts from Fromm's point of view: man is the center of his life, the growth and realization of human individuality is a target which can never be subordinated to other purposes, which are supposed to have greater dignity. As a matter of fact, according to Fromm, the average man is often not really aware about his life and his reality, since most of what he thinks is real is only a sort of illusion: often he is aware of reality only to the necessary level to carry out his activity in his own social context and cultural context to which he belongs, as his survival targets makes such awareness actually necessary [1].

2. The self and the culture

Throughout the humanity history we have witnessed a revolution about the reference values, with respect to the man role in culture and in social development. While Western culture fathers (the Greeks and Jews), believed that the supreme life target was man perfection, modern human beings often look more and more to things perfection, and to the knowledge of methods to produce these perfect objects. The long and complex transition from a "humanistic" society to a "technological" society have repercussions on the personality development (and therefore on the human self development [2]), since it embodies the process through which society transmits its cultural system from one generation to another, creating

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values, style of life ideals, social roles, habits and customs, language and expressive behaviors. In this regard, during the twentieth century second half, both in the anthropological field and in the psychological area, particular attention was given to the culture study, realizing how it has a strong influence on people's life, making available different belief systems and values. The questions that man think are therefore affected by his own context: it influences individual experiences, how he perceives reality, how to satisfy fundamental needs, etc. The culture, which in the past was considered an outside objective frame, today is conceived as a sort of individual "internal" dimension, like a part of human self, and as a constitutive basis of individual behaviors: this makes us think on how the limits between "interior spaces" and "exterior spaces" are blurred and mixed. Thus, we can ask ourselves how profound is the culture influence on human being? We know, for example, that the probability that certain emotional experiences became conscious depends from the specific culture context in which they are experienced. According to this point of view, we can therefore affirm that an experience for which a specific language does not have a corresponding word to represent it rarely comes to man's awareness: language embodies a certain disposition towards life, and can therefore be defined as an expression of a certain way of experiencing life [1]. According to this perspective, the psycholinguistic analysis that can be made with respect to verbs and nouns use in various languages is really interesting. The cultural paradigm shift from the self development to the technology development is represented by the growing number of people that today prefer to think in terms of having something, rather than in terms of being and acting: there is actually a preference for the use of nouns, instead a preference for verbs. Language, grammar, and words are indicative of the way and perspective of our life experience, and establish which kind of experiences can have access to our awareness (if there is not a term to indicate an experience in our language is difficult to became aware of this specific aspect). It is often believed a language differs from another only because it uses different words to mean the same thing, erroneously assuming some thought pattern and rules are universal, but this fact is not true because thought is influenced by a cultural system, which can show some conflicting logics with other cultural systems logics; thus, the individual often cannot afford to be aware of thoughts and feelings that are incompatible with his cultural models (according to which he grew up), and he is therefore unconsciously forced to remove them. About this topic, Fromm states that the conscience represents the social man and the contingent limitations imposed by his historical situation and context. In summary, we can note that the psychological functioning is therefore "intrinsically cultural", since persons reason about the world using language and communication systems that acquire in their own culture, which are the product of human generations' cultural experience; furthermore, we must focus that the themes to which individuals think about have a personal meaning within systems of meaning, based precisely on cultural and social practices, which are different according to context. We must point out, moreover, that the cultures are built by the same people who acquire the sense of being individuals from this same culture: the personality (the self) and culture structure each other; as a matter of fact, the proper significant culture customs and psychological processes of each of its members are mutually interacting [2]. In this regard, for example, we can also assert that there are collectivist cultures and individualist cultures, present more frequently respectively in East and West countries: how are they related to the constitution of the Self, and vice versa? The collectivist cultures place emphasis on membership, and on the shared rules that govern the community relationships: the person often define himself as part of the social community, since there is an intense emotional attachment to the largest social group to which he belong (not only to the family, but also to wider society); in this context, the self is often very

focused on cooperation and social control. Therefore, people who refer to a collectivistic perspective more frequently pay attention to others and attribute greater relevance to contextual and external factors to explain a certain individual action; instead, individualistic cultures, often give emphasis on the "ego", emphasizing the importance of personal autonomy, success and self-sufficiency: the self is often defined as an distinct entity from the social group in which it is contextualized; this perspective encourages to reach personal objectives. In this cultural framework, the personality is more oriented towards autonomy and competition values. People who refer to an individualistic perspective frequently give importance to individual responsibility in the explanation of the behavior causes [2]. Finally we have to state that the idea that Oriental culture and Westerners culture have created a sense of a more interdependent human self (in the former case), and a a sense of more independent self (in the second case), is blurred by the globalization phenomenon. This dynamic has been made possible by technological achievements (especially telematic ones), and has involved the entire planet in many areas: international exchanges have increased at an economic level and, consequently, also political, social and cultural one. This fact has led to a new worldwide phenomena emergence, both in the East and in the West countries: individual and context are not independent, but are interacting with each other in a dynamic way, and they really create each other [2]. The individual considered isolated is therefore a pure abstraction: he is a part of an articulated relationship system not only with the physical environment, but also with the socio-cultural and relational environment that surrounds him: we can therefore also ask, today, how hyper-modern era influences the ideal self and the real self, in various contexts, and vice versa.

3. Self and economy

The communications speed, the reduction of the space–time distance between the various countries has paradoxically caused increasing social disparities, the exploitation of wage labor and the reduction of the local economies autonomy. From an individual level, globalization has also promoted a sort of needs homogeneity, often standardizing the individual tastes to an imposed standard influenced by advertising. Another globalization consequence is the fact that it favors the ideological visions conformity and the lifestyles conformity, determining individual identification with the consumers mass. Paradoxically today in parallel there is also a generalized individualism. Assuming that the specific economic aspect is important for human development, however, it is necessary to explain why, despite the globalization pressures, different populations live in socio-economic conditions which are often very different from each other; even in the same context of the industrialized world, and in the "rich nations", there are profound social inequalities regarding earnings, and consequently regarding the opportunities that individuals can have: today in many nations, the differences in economic conditions between poor and rich people have widened. At this point we can ask ourselves: which influence do these socio- economic circumstances have on the development of the individual self? In this regard there are some scientific evidences [2], for example, considering a particularly important and complex issue: it have been observed that individuals living in environments characterized by low and medium socio-economic conditions, often experience higher levels of psychological distress, such as depression and anxiety; this result may appear very ambiguous: it is not clear whether the individual personality characteristics indicate that they reside in more disadvantaged neighborhoods, or if it is on, the contrary, the fact that they live in these neighborhoods which can cause psychological malaise: thanks

to scientific research it has emerged that between these aspects there are complex and significant interactions. Some studies have been carried out on this topic [3–6] and of a very important result emphasize that the relations of cause and effect vary precisely according to the personality characteristics. We can ask ourselves is it the personality that exerts an influence on the social class or if it is the social class that influences the personality? It has been observed that social circumstances and self are deeply connected to each other: the children who grow up in disadvantaged families often become more anxious adolescents, and adolescents who have access to a lower education level often become more anxiety-prone adults; the relationship, however, does not seem to be one-to-one: the available data show how anxiety can develop from predisposing social contexts but that the reverse phenomenon is not so evident. In contrast, the data regarding antisocial disorders revealed a different result: the antisocial behavior has a social class effect; as a matter of fact, individuals who exhibit antisocial conduct show more difficulty at school, which in turn create a negative economic condition when they are adults. In general, scientists are able to explain the mutual influences of personality and economic status/social class but only by specifying the exact personality characteristics and studying the people development over time (through longitudinal studies) [2]. From what has been explained up to now, it is evident that the social, economic and cultural context can influence the self development, as well as the personality structuring can in turn determine important consequences in the various socioeconomic contexts.

4. Real self and false self

The individual grows up and evolves influenced by his genetic characteristics and by the events that he has experienced during his life, in various contexts in which he lives; perceptions that the individual harvested from his experiences form his own inner world. When reality reaches awareness (and is psychologically represented), it substantiates the perceptions set that represent individual experiences; we must therefore focus that the human being does not react to reality as it is, but he reacts to his own perception of reality itself: therefore, each person can develop a different perception of a specific situation, and in general of the surrounding world, this process is also based on the concept that a person has of himself. At the development beginning, the child recognizes a part of his own experience as “me”, “I”, “myself”: this is the first part of “self “; therefore emerges the awareness of existing: the set of perceptions relating to oneself, which influence the perception of the surrounding reality. The set of meanings that the child attributes to what he calls “me” or “I” constitutes “ the self core”, which continues to develop during human growth. The self is a conceptual, organized and coherent perception configuration of personal characteristics: it is a fundamental personality structure, and it is very complex [7]. In summary, term self refers to the whole person as a reality, including his body and his psychic organization [7]. It may also be observed that one of the first and most important experiences that a child has of the self is the experience of being loved by his parents; as a matter fact, an important variable in the pattern towards self-realization is precisely the need to receive positive consideration by others: this is a particularly strong desire of the infant, who expects that the people who take care of him are ready to love it and accept him. Parents positive consideration can be, however, “unconditioned” or “ conditioned “, but what do we mean with these terms? In the first case the child is fully accepted as a person, regardless his behaviors, in the second case, child is welcomed and accepted only if he adapts to the parents expectations: “value conditions” are therefore set. Basically, the child feels to be considered and loved only if he welcomes certain parents’

needs; we also must specify that, according Alfred Adler, the feeling to be inferior is an experience that has its origins in infancy: the children feel inferior, because they are always surrounded by more powerful individuals (adults). The child then is very influenced by adults, and usually try to emulate them because he is motivated by the social environment that drives him to achieve some results [8]. How can we contextualize this situation today? The subjectivity affirmation, a last century conquest which appears to be historically consolidated, is perhaps not really guaranteed today as regards the possibilities of individual development. Today attitudes towards offspring appear to be diverse and complex. According to some authors, children today are often objects of emotional consumption [9, 10], because they can satisfy the parents needs (who can therefore set more often than in the past "value conditions" for the child acceptance: "you have to behave in this way to be loved"); as a matter of fact, it is not infrequent parents pour their unprocessed emotional needs both in the couple relationship and on the offspring, and they express also their existential problems in the relationship with their sons: when you feel you have not been able to give meaning to your life, then you try to reach one by dedicating yourself voraciously to your children [9, 10]. According to other authors, however, today children are also often valued as owner of rights and needs and as the family affectivity fulcrum [10]. We can ask ourselves if perhaps children today are often the protagonists of a family affectivity based not infrequently on emotional consumerism (and therefore, implicitly, on "value conditions")? Consumer goods meet the desires, and even a child can satisfy many specific aspirations: he metaphorically opens the door to the "joys of parenting, " which nothing else can provide, and many parents expect an emotional satisfaction that justifies this expensive investment [10, 11]. As a matter of fact, often parents have high expectations towards the children: the offspring is therefore invested with vital expectations for parents 'self-esteem, and the child is therefore often aware of always being judged, and can internalize the continuous judgment his own [12]. Parents can manifest narcissistic needs towards children, and they can create the conditions for the institution of the children inability to distinguish between their real feelings and the efforts to please or d impress others. The ambiguous message of being appreciated, but only in the particular role that they play, can let the children believe that if their real feelings are discovered, they will be rejected and humiliated. Thus, the creation of the "false self" of which Winnicott wrote can therefore be stimulated [13]: only those aspects which are considered acceptable are shown to others, according to what has been learned in the primary infant experiences [14]. When the child experiences a "conditioned" positive consideration in the relationship with his parents, he will therefore tend to behave in a way that neglects his true nature, in order not to lose respect and love. When his experiences are in contrast with the "value conditions" set by the parents, the child will perceive a discrepancy between the real self and external the experience. He will then use his own defense mechanisms, but he will no longer feel really himself, he will find difficult to recognize himself, maybe he will experience a state of inauthenticity, and this leads to an alienation state [1–12, 15].

5. Real self and ideal self

The personality is a representations organization that that everyone own [13], and in this regard we can state there are various self form among which we can mention:

- Real self: the one who reflects the individual true qualities, his aptitudes, inclinations and characteristics.

- Ideal self: that is constituted by the characteristics to which the individual aspires. It is a guide of the self.
- Imperative self: what the individual feels he must be [13, 16], it a guide of the self too.

Evaluate yourself means also to compare with your inner canons (also called the self guides), these comparisons can arouse negative or positive feelings about yourselves; it is also appropriate to specify that while most of the time our thoughts are turned outward, some events can create a state of intensified self-awareness, which confronts you with your inner canons (this may be the case of the comparison with with some social idols, like the perfect rich top model). Focusing the attention on the self makes also obvious discrepancies with respect to the self guides: this happens because the knowledge of the self includes beliefs about you, and also about the comparison with the royalties to which you try to conform to. Self-esteem is therefore influenced not only by what happens outside, but also by what happens "inside us", that is the comparisons with the ideal self, which includes the traits that help to achieve some aspirations, and the imperative self which instead includes the traits that spur to fulfill one's obligations. The self guide are useful for the auto-adjustment function: the discrepancy theory says that there is a the difference between the self guide and what people think to be, and this discrepancy can influence the individual emotional state and the well-being, it also influence our self-esteem. Focusing on these topics, we can assert that the ideal self represents the positive outcomes that people try to achieve, therefore their goals for advancement: discrepancies with respect to the ideal self can produce disappointment feelings, sadness and depression. On the contrary, when you actually achieve progress targets the emotion that derives is joy. The imperative self is focused on the negative outcomes that people try to avoid, that are the prevention goals. The deviations from the self imperative stimulate anxiety and restlessness feelings. Achieving the objectives of the imperative self produces instead relief and relaxation feelings [17]. Thinking about our inner canons can make us aware of our self discrepancies, activating an emotional response among those mentioned above, and one's own canons can also focused by thinking to specific people who represent them, that is, who can embody idols (i.e. a perfect top model). The construction of ideal self and imperative self often refers to idols supported by the propagation dynamics of globalization both in the Western and Oriental Countries. The propagation of certain myths and idols can therefore constitute a real problem when the real self and the ideal and imperative self come into conflict: the person experiences incongruity: an unpleasant experience, which causes a sense of inadequacy, anxiety, malaise and maladjustment [16]. Incongruent experiences with respect to the self, on the other hand, are perceived as threatening and anxious, and often activate some defense mechanisms, such as the distortion of the meaning of the experience, i.e. the manipulation of the experience itself (because this dynamic can make it compatible with the self), or even denial of experience. On the contrary, a smaller the discrepancy between the real self and the ideal self and imperative self can create wellness: the subject is in harmony with himself. The so-called "white psychosis" can have a diffusion in these conditions of discrepancy. They are characterized by confusion, loss of the sense of reality, denial of reality itself, disorganization. These states are also called "private psychoses", perhaps also to underline the dimension of individual closure that generates them, the inability to open up in a sane way to the world and to the other, maintaining their own authentic individual identity: they therefore reveal themselves conditions that prevent a process of healthy individualization [18]. A cause of psychological malaise can therefore also be living constantly

trying to correspond to the environment expectations, precisely to fill the incongruity between the real self, the ideal self and imperative self. As a matter of fact, the self, in its formation and evolution follows the law of congruence: it constantly aims to seek coherence between its own self-perceptions and between these and external reality [16, 18, 19]: when the self is congruent with experience, the individual is fully functional and healthy. On the contrary, when the incongruity between the self and personal experience is so strong that it does not allow the successful application of the defense mechanisms, the person can develop a psychological state of disorganization, as anticipated.

6. Self-esteem and self-expression

As anticipated, in the independent cultures (Western, especially "Protestant" ones) the positive characteristics of the individual are the ones which are the most important for self-esteem, while for interdependent cultures (Oriental ones) is more considered the affiliation to others [2]. Beyond these differences, in all cultures self esteem performs the function to indicate how the person is behaving in life (in a right way or not). According to Alfred Adler, children and adults with a balanced and healthy personality, universally acquire confidence and self-esteem every time they are aware of being able to reach a goal: in synthesis, the sense of inferiority is resolved when a new challenge is overcome [19]. The self-esteem levels therefore play a crucial role in this process, precisely because they are signals how effectively the individual is acting. An accurate knowledge of own capabilities and preferences is also important because can guide a person through his existence, and d helps him to live in a manner more appropriate regarding his own needs and abilities. Self knowledge also represents as a reference for perceiving other people, and it influences what types of social aspects are more considered. It must also be noted that sometimes we act in such a way as to express our authentic self, other times, as anticipated, we can act because we want to shape others opinions about themselves, in order to gain power, influence or approval [2, 13]: in this consists the difference between self-expression and of self-presentation. When you dedicate yourself to self- expression, you try to convey the concept you have of yourself through your actions. The self-expression and communicates it to other people, and it that can even work as a powerful reaction strategy when we are under stress, and can also beneficially affect out auto-immune system [16]. The self-presentation is however only our attempt to create a good impression, to please other people and to obtain confirmations by others, to increase self-esteem and strengthen out ego. Well-being, on the other hand, goes in another direction. According to Fromm [1] the well-being is different to narcissism. Well-being means becoming what one is really, it means being fully open to joy and sadness. Wellness means being fully awake, it also means being creative and authentic, being able to express our real self [1].

7. Finally becoming yourself

The self-expression helps people to meet their real emotions and their real self: also simple forms of self-expression, for example, talking about feelings caused by threatening events, may help overcome some of the physical and emotional costs of those events [16]. Self-realization and self-expression are indeed among the highest needs on the scale of human needs, and certainly affect human health [20]. The need of self-expression, specifically, is the need to use our talents, abilities and potentials. Self-realization and self-expression can therefore be briefly defined as

the courage to be yourself; in this regard according Kierkegaard we can achieve harmony and inner peace only through the courage to be ourselves, instead of trying to be like someone else (or want to please someone else); he was convinced that despair vanishes the moment we stop denying who we really are and try to accept and discover our real nature. According to this author, the opposite of despair consists in really wanting to be who one is [14]. Fromm believed in this regard that we can make life better, even if it is painful at times, by giving it meaning by seeking and developing an authentic self. He believes that man's innate existential condition is a state of anxiety, which however can be overcome by finding one's purpose in life: by struggling to become free and unique individuals. As we have seen, however, at the same time we always feel the need to be in relationship with others, and to confront ourselves with a social group; however, it is very important in parallel to discover one's own independent self, one's opinions and one's values, rather than always adhering to pre-established norms, imposed by one's neighbor, or by the reference culture; according to Fromm we become precisely alienated if we try to delegate to others the responsibility of our choices, we could add, if we modulate all our conduct on the basis of self-presentation and the others' satisfaction. The purpose of life, according to this author, is to define ourselves, accepting our personal uniqueness, and discovering our abilities: it is very important to focus on what differentiates us from others. In this way it is possible to free oneself from alienation, confusion and loneliness; we must discover our individuality, understanding our true passions, inclinations and ideas, setting ourselves a creative purpose in life [1, 21]. However, there are several types of personality that can hamper personal and true self-realization, among these are: personality receptive orientation (ie those who live passively and accept the fate in a fatalistic way, those which behave as gregarious complacent); people which have an demanding orientation, that usually use other people like and object; the accumulators also show a pathological orientation: they are constantly looking for a social climb and consider the people they frequent as property. These kind of personalities are far from the development of an authentic self; finally there are those who have a mercantile orientation: those who are obsessed by their own narcissistic image and by their status (and this is the type that most represents modern society). A healthy personality type is the productive one: it is that who show flexibility, creativity, sociability, rationality and mental openness; this kind of people develop a high level of consciousness, willing to change their beliefs in the face of new evidence, and to evolve. Thus, the human health is conceived as a dynamic process of evolution, rather than as an end state, and certainly in this process are the fundamental expression of one's self, a healthy self-esteem and personal development; the value that a person thinks he has, is therefore not only in the result of his individual actions, but in representations that are built over time and evolve in the life process. The Well-being human involves in fact the expression of a v auction range of potential: intellectual, social, emotional and physical one. In the field of scientific research, therefore, an attempt has been made to identify indices that can be measured in this regard; when examining the characteristics of the Welfare reported in these various theoretical formulations, it is noted that the various authors have spoken of similar features. A certain number of indicators of good psychic development were therefore obtained, subsequently putting them to the scrutiny of empirical experimentation. Thus, the following six dimensions were identified:

1. A true purpose and a sense of direction in life;

2. Personnel development;

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3. Good relationships with others;

4. Persona control and effectiveness;

5. Self-acceptance, self-respect, self-esteem;

6. A autonomy [17, 22–24].

This is non-definitive list and will certainly be reviewed or expanded [17, 22–24], but in any case we can say that regardless of the reference culture there are some dimensions which focus on a healthy individualization: the overcoming of the limits of a selfish ego, the conquest of love, objectivity and humility and respect for life, until the end of life is there life itself and man becomes what he is in potential [25]. The malaise can instead be represented by the alienation from ourselves, a malaise creeps into the awareness that life slips from our hands like sand, that we will die without having lived. Today there is also a more and more frequent paradox: while narcissistic individualism as an unlimited self-affirmation increases on a world scale, the idea of a subject who feels he is part of a human and natural totality often disappears. As a matter of fact, being an individual often coincides with the claim of the right to the immediate and mandatory satisfaction of one's desires, where the one who has more economic power, can impose himself on the weaker people. We must also consider in this regard, as Byung-chul Han reminds us, that we live in a society that is becoming increasingly narcissistic, and narcissism is definitely not a form of self-realization or self-love; following this narcissistic attitude today almost nothing has a long shelf life, and everything is disposable, also relationships, and this has harmful consequences [26, 27]. We can therefore ask: what can psychoanalysis can offer to those suffering from sickness of the century (ie. narcissism and alienation)? This is an aid that must be different from the only treatment aimed at the removal of symptom, which can preserve the normal performance of social functions. Because for those who are alienated (ie for those who are far from living fully their real self), the goal cannot be only in the absence of disease, but in the presence of wellness. A first definition of Wellbeing can therefore be the following: wellbeing is being in harmony with the nature of man. However, if we go beyond this formal statement, a question arises: what does it mean to be in harmony with the conditions of human existence? And what are these conditions? The human existence arises a problem. Man is thrown into this world not by his will and so he is torn from it. According to Fromm [1, 25], unlike the animal, man does not have an immediate innate mechanism in his instincts, which allows him to adapt immediately and completely to nature. The questions that life poses are many: how can we overcome the pain, slavery, shame caused by the experience of isolation? How we can find the harmony with ourselves, with our fellow humans, with nature? Man is required to give some answers; he even responds in case of madness, rejecting external reality and living completely enclosed in his selves, to overcome the fear of loneliness. Therefore, the solutions that can be worked out, in response to the existential questions, are basically reducible to two. One is to overcome isolation, to find unity through regression to the state of primordial harmony, existing before the awareness development (ie before birth). The other solution consists in being metaphorically completely born, in strengthening one's awareness, one's reason, one's ability to love to the point of overcoming one's self-centeredness and narcissism and thus reaching a new harmony, a new communion with the world. However, most proceed along the life pattern are far from wellness: attached to their family (in a symbiotic way), or attached to the state, the social rank, to idols, myths, and etc. To be able also to understand the individual patient, and d in general any individual,

it is important therefore to understand what his response than human existence to these question, ie what is the object of all his passions and all his efforts. According to Fromm what are considered psychological problems are often consequences of this fundamental answer: it is very important to know the fundamental answer that the subject has given to the existence problem, in a certain sense his secret and private religion. As a matter of fact, man often tries to compensate for his depression with idolatry, with destructive tendencies, or with the fame desire and the desire for possession. And when any of these solution fails, his fragile sanity crumbles. The cure for potential madness therefore lies in the passage from alienation to the creative perception of the world and harmony with it: a man cannot be truly free if he is a slave to his passions. He can be free only if he has an ideal and a philosophical attitude which makes it possible for him to have a consistent activity in life [1, 25]. By ideal we obviously do not mean an idol. As Zoj a stated [28] modern culture is characterized by the conviction that in each of us there exists a personal psychological dimension, which everyone has the right to explore and to consider a source of knowledge, aiming to broaden it. However, it often happens that this disposition arouses a sense of solitude and incompleteness. The current situation of frequent alienation can therefore be considered as a symptom, not to be healed in order to return to a previous situation, considered healthy, but as a signal and message: the subject produces a symptom, as a sign of a discomfort that has now exploded, so that he himself can change the its situation. The first step, therefore, is to become aware of the current limit condition: the split between self-perception, emotion and thought, which has become the norm and narcissistic closure in one's own needs. The further step is the acceptance of the limit of our human being not as a condemnation, but as a push to increase knowledge and creativity in the essential relationship with others with whom we are linked in a common destiny.

Author details

Floriana Irtelli[1]*, Federico Durbano[2] and Barbara Marchesi[2]

1 Catholic University of the Sacred Heart, Milan, Italy

2 Melegnano and Martesana Hospital, Melzo, Italy

*Address all correspondence to: dott.ssaflorianairtelli@gmail.com

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Section 2

Psychoanalysis Overview

Chapter 3

Freud and Binswanger: An Asymptotic Relationship

Philippe Veysset

Abstract

The relationship between Freud and Binswanger can be thought as a productive misunderstanding. In search of institutional recognition, Freud sees in Binswanger above all a representative of classical psychiatry, moreover director of a prestigious institution, while the latter aspires to shatter this same psychiatry which seems to him marked by the discrediting of the patient. This misunderstanding will take the form of a doctrinal rather than a practical disagreement, centered on the notion of drive - too biological according to Binswanger - and in particular on the latter's refusal of the drive origin of the ego and of the censorship. For Binswanger, psychiatry can renew itself from the inside by opening up to a philosophical, phenomenological, approach to the patient and his world, a world in which it is first necessary to enter through a patient-doctor co-journey in order to reconstitute the conditions for living together. For Freud, the therapeutic imperative proscribes such recourse to an external authority, the world of the philosopher being itself, by its closure on itself, suspect. In the end each of the respective thoughts of the two men will progress in contact with the other without ever a perfect agreement being able to take place.

Keywords: Freud, Binswanger, phenomenology, psychiatry, drive, ego, psychoanalysis

1. Introduction

The relationship between Sigmund Freud and Ludwig Binswanger began in 1907, when at the invitation of C.G. Jung, then medical director of the Bürghölzli and heir-apparent of E. Bleuler, Binswanger accompanied this one to Vienna, to the famous Berggasse, 19, both residence and study of the master.

At the age of fifty-one, Freud was already famous at the time, notably through *Studies on Hysteria*, co-authored with J. Breuer, published in 1895, and *The Interpretation of Dreams*, published in 1900. Famous but not recognized. He′is the subject of disputes which, often, concern more the mood or the emotion than of a solid scientific test, of a clinical or theoretical order, thus on behalf of the German psychiatrists. He also suffered ruptures (Breuer, Fliess).

Suddenly, to spread, his thought takes the path of local (national[1]) associations. He also shows himself more and more in favor of what he calls "wild analysis" (that is to say layman = carried out by non-doctors).

[1] They will eventually come together in an international Association, whose first president will be C.G. Jung.

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However, its need for institutionalization remains great. He knows that this can only take place by associating himself - who moreover is not a psychiatrist but a neurologist - with "constituent bodies", bodies whose institutionality does not exclude a certain degree openness to new methods of investigation and therapy. Institutions, too, where he could test, life-size, the veracity of his medical doctrine. Of course, with Abraham, Jung and Bleuler, won over to his ideas, the Bürghölzli, famous Zurich institution, both asylum and hospital which, at the time, was at the forefront of research in the treatment of mental disorders, is not inaccessible, but Freud perceives resistance.

It is here that the meeting with Binswanger will prove to be crucial for him. From Freud's point of view, Binswanger embodies both traditional and institutional psychiatry. These two terms have a different meaning. Binswanger certainly embodies the institutionality that Freud needs to affix an official seal to his work. But he also embodies, by that very fact, a way of thinking that he tries to shake up with his incredible theoretical fecundity and inventiveness.

Binswanger is, vis-à-vis his interlocutor (twenty-five years his senior), in a different posture. Heir to several generations of psychiatrists (his uncle Otto, installed in Jena, treated Nietzsche), he is preparing to take over the management of the Bellevue clinic, located in Kreuzlingen, Switzerland, what that unfortunately will happen sooner than he thinks (his father died in 1910, when he was barely thirty). His interest is therefore more of an intellectual nature - he has not completed his thesis - and undoubtedly, therapeutic. It is important to underline that, in parallel with medicine, he studied philosophy at the University of Lausanne and Heidelberg. But, perhaps precisely because of this double formation, Binswanger will also try to "recover" Freud, obviously not at the level of any institutional basis but, one could say, symmetrically, at the level of the elaboration of his own doctrine which would later become existential analysis, Daseinsanalyse. He would later write: *"The struggle with psychoanalysis as a science and branch of psychiatry runs through my life. I can say that all my scientific development, in its positive as well as negative aspects, has been played out on the basis of the philosophical and scientific controversy with psychoanalysis..."* [1].

Although built in chiasmus, a strong link will therefore be established from this meeting, a link which will last until Freud's death without experiencing any interruption (despite the war) and to which regular correspondence testifies, if not nourished, between the two men, correspondence partly lost - the medical files in which certain letters were slipped have disappeared or remain inaccessible, and partly published in french language (Calmann-Lévy, 1995). This strong bond should not however leave in the shade the rough edges to which it was able to give rise. Binswanger, for example, will ask Freud why it is his most brilliant students who abandon him (Jung, Adler ...) and openly reproach him for his will to power while Freud writes to Ferenczi that Binswanger, decidedly, "is not gifted,"

The doctrinal dissensions between Freud and Binswanger which will end, in the latter, in a virtual silence until the death of the former, therefore inform us first of all about the internal economy of the relationship between the two men and, if we are to understand it. Let us approach first, this does not mean that its place is less important. It is clear that, if Binswanger hoisted the flag of phenomenology in 1922,[2] he only really formulated his doctrine with the *Grundformen... (Fundamental*

[2] *AboutÜber Phänomenologie*), presentation given at the 63rd meeting of the Swiss Psychiatric Association in Zurich, testifies to the interest shown by Binswanger, from 1922, in (Husserlian) phenomenology. Binswanger met Husserl in 1923 (possibly following treatment from Madame Husserl, the couple having lost a son during the war). It is also important to note that both Husserl and Binswanger had in common the fact that they came from a family of Jewish origin converted to Protestantism, Freud having preferred an atheism which he explains in the last section of his work ("En matter of religion, I cannot help you" he will say to Binswanger in 1927).

shapes and knowledge of human Dasein) which appeared in 1942 and did not announce his method until the first International Congress of Psychiatry which was held in Paris in 1950, twelve years after Freud's death.

Echoing this late statement, we must underline the apparent continuity of clinical and therapeutic practice, but here again, this continuity informs us first of all about a conception of the relationship between theory and praxis, what Binswanger calls the "understanding" of the patient, a "understanding" which does not mean the abandonment of the therapeutic action (this accusation will be addressed to him after the suicide of Ellen West) but that a new understanding of the disease as an existential experience cannot be without consequences on the concept of care and "healing".

2. Doctrinal disagreement

2.1 The unconscious and the conscious

The Freudian doctrine of the unconscious received a formulation completed - if not definitive - in 1915 [2]. We will not enter here either into the history of the notion which from Leibniz leads to Maine and Lipps [3, 4], to which Freud explicitly refers in his Letter to Fliess of 27-IX 1898, nor into the content - necessarily random - of its definition being a question, Freud will not stop repeating it, of a concept released from the very practice of the cure. What matters here is to remember that, for Freud, the Ucs originated in the genesis of the psyche and that it is from it that consciousness is constituted, including in its more evolved form which is the ego.

We find for example in his letter to Binswanger of July 4, 1912 this affirmation (literally taken from Lipps): "The Cs is only a sensory organ" on the margin of which Binswanger notes: "*I was never able to rally to this conception, resulting from the primacy of id.*" [5].

This consciousness, which Freud prefers to call conscious, this ego, are labile phenomena, evolving at the same time as dynamic: *"Thanks to the work of interpretation which transforms the unconscious into conscious, the ego expands to the detriment of the unconscious"*, notes Freud in his *Introduction to psychoanalysis* [6]. Initially suspicious of libido, "puny and infantile", this ego, which has become "stronger", feels, through the treatment, capable of subsequently welcoming this same libido. The functional success of the treatment attests to the primacy of Ucs over Cs, it is this success which is first of all a success for the body, a calm and happy body, which remains the touchstone.

For Binswanger, language is the key to both illness and cure (and cure). *"The phenomena whose content Daseinsanalyse interprets are phenomena of language"* and when Freud thinks he is interpreting dreams, he only interprets the narrative.

He goes further: if language can heal (talk cure) it is precisely because evil, at its origin, is linguistic in nature, that it is, as a process of signification (making "sense towards", therefore), which helps the patient to build his "world project", the only substrate for a solitary freedom which otherwise goes mad. The madman is therefore never "as mad as that" (even if his project is initially incompatible with the common world, that of living together where he must be reintegrated). This is what will bring Binswanger closer to Heidegger, for whom speech, before being a tool of communication, constitutes the fundamental existential, the "house of being" and whose deterioration (chatter) removes Dasein from the Being and stucks it in the One. It is also this position of Binswanger which inspires J. Lacan for whom *"the Ucs is structured like a language"* (including, therefore, in its dislocations: we remember

the "galloping, did you say galloping?" quoted in example by Lacan in the third *Seminar*).

Hence, there is something absurd in claiming that the consciousness which necessarily accompanies speech (not in its meaning - innumerable and proliferating - but in its "signifiance") can come from the Ucs. When Freud listens, he listens to a word, when he makes a diagnosis, it is to the medical lexicon that he resorts to, when he heals and finally cures, it is through the word.

This obviously does not mean that the body is evacuated, but it is no longer the Freudian body, not even a Freudian body subject to (institutional) constraint. Nor is it the body revealed by Goldstein's work, the "organism": even if language cannot be dissociated from the very fine bodily mechanisms revealed by aphasia (an aphasia to which Freud devoted his first work), it is always from him that the impulse for meaning starts. It is a body brought back to its primitive and essential function of focal point of the "directions of meaning" with the help of which space is constructed and ... there is no world, no world-project without space. The debt to the Husserlian doctrine of the body, like *Nullpunkt* (zero point) of space, is important: space is precisely what must cement, what cements, the world and the world-project.

Even if language cannot be entirely related to conscious mechanisms, even if "it speaks in me", it is always in *me* that it speaks. In me and in the other.

To place the precession of the Ucs on the conscious, as Freud does, would lead to therapeutic mutism.

3. The drive: how can censorship reside on the drive side? The question of narcissism

It is somewhat the same circular structure (and therefore the same reproach) that emerges with regard to the drive or even, although its field is more restricted, of the libido.

First there is a libido-ego question. How distinct are they? According to Binswanger, Freud practices here a radical opposition; according to Freud, Binswanger is practicing a radical caesura here.

In his practice, Freud often opposes the two instances. He goes so far as to define the pathological by an outbidding of the libido on the ego. In a letter of July 24, 1913, Binswanger remembers a conversation in which Freud evokes the case of a yawn (compulsive or normal, this is not specified and may be unimportant) where the ego, faced with an invasive libido, "Can no longer exert power on the function". If this opposition, manifestation of life, is made possible by their common origin, the fact remains that the ego must once again become (or rather: become) "the sole master in the dwelling".[3]

Binswanger, for his part, poses a priori, as we have seen, a radical distinction between the two bodies. For the libido-ego link to be established, they must have a (partially) common nature. This is the point of disagreement, Binswanger defending, at least at the time, the existence of a "transcendental" ego.

However, in practice the opposition is markedly reduced. This attenuation is made possible by the intervention of a concept which rejects, once again at the theoretical level, the traditional dichotomy between consciousness and matter: Dasein, in its fundamental structure of being-to.

[3] Cf this sentence in which Freud comments on Jung's increasingly hurtful attitudes: "I have withdrawn my libido from him" (Letter to Binswanger of July 29, 1912).

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Of course, Binswanger will gradually reintroduce the notion of subjectivity and even consciousness in his reflection and this reintroduction can legitimately be interpreted as a belated reconciliation with the Freudian position. This ego, however, is no longer quite Freud's. In particular, it must be conceived in its relation with another ego, an ego with which it becomes one from the start and that the doctor-patient couple tries to reconstitute (notion of *Miteinandersein, being-which-each-other*):

"The ipseity of this me and this you is therefore not at all founded in Dasein as mine or yours, but in Dasein as ours, in other words in the Being of Dasein.

as nostrity. It is only from nostrity that ipseity takes off" [7].

On the one hand, therefore, a genesical ego, slowly resulting, by federation of drives, from an unconscious structuring. On the other hand, an ego has fallen, through the work of concern, to a We posited as the fundamental structure of a Dasein (the Binswangerian We is not a mediation between an ego and a generic humanity (an "they") but a mediation between an Ego essential to medical practice and a Dasein defined by its presence in the world and not by its consciousness, an unconscious Dasein at bottom. The unconscious is Dasein.

The tension then seems to be loosened. But this is only appearance. It will in fact resurface through therapeutic practice and in particular, censorship: is this really of an instinctual nature, even if, as Freud would say later, a drive which, after having been itself censored, turns against other drives?

Let us note first of all, in order to exonerate Freud from a new accusation of naturalism which Binswanger, later on, will partially withdraw, that the Freudian drive is not exclusively a physiological phenomenon. It is, Freud noted, *"a concept limit between the psychic and the somatic (…) of a chemical or mechanical nature, it aims to bring to the outside world what is necessary of modification to satisfy the internal source of the excitations"* [8]. It is a corrective mechanism.

As a corrective mechanism, censorship emerges from a dynamic identical to that of the drive, even if, obviously, the correction is not carried out according to the same mode (it should be noted, however, that Freud will go towards a progressive unconsciouization of a censorship replaced by repression). However, if censorship, whether or not it operates in consciousness, is endowed with an instinctual nature, *"how is it that it has sufficient authority to censor other drives?"* For Binswanger [5], this authority can only come from an external legitimacy, linked to a device necessarily exceeding the drive flow. For Freud, this exteriority does not exist.

"Freud," Binswanger continues, *"remained of his opinion which he subsequently sought to found in narcissism"*. What is it about?

In the first Freudian conception, Freud defines several types of drives (sexual, hunger, thirst, scopic drive …) which will finally be organized around a sexual drive/ego-drive or self-preservation pair. In a second conception, an erotic drive/death drive or destructive pair emerges. The sexual drive retains the preeminence because it carries within it a negativity that others do not carry. Now this point is crucial because it is because of this negativity and the dialecticity that it gives rise to that *"something in the nature of the sexual drive is not favorable to the satisfaction of the sexual drive itself"* (*ibidem*).

What happens in narcissism, the theory of which is precisely worked out after Binswanger's third visit ("To introduce narcissism" dates from 1914)?

Freud begins by recalling the existence of the primitive ("natural") state of the libido that is autoeroticism, which is pure pleasure-taking and dispenses with the mediation of the other (it is not therefore not strictly sexual - any "sexus" induces a separation, a cleavage as the word indicates). Then a choice of object is made,

the first decentration of the libido. Normally, it is the mother or her substitute (for Freud) who constitutes the first object.

However, in certain cases, notably in the absence of a strong father figure, the choice of object turns into a fixation on the mother (for Freud), no longer therefore as an object but as a subject of love. It is the very love of the mother that is desired. We then want to love as the mother loved and in particular by adopting as the object of this love the same object that the mother loved: oneself.

A second step is constituted by the establishment of a choice of homosexual object when, forced all the same to choose an object, one restricts the extent of this choice by adopting an object that has the same characteristics as oneself, in particular the same genitals, those of a boy (who can be the father) if one is a boy, those of a girl if one is a girl (in this case, more intensely because the identification with mother was stronger due to bodily similarity: this process is illustrated by the study on Leonardo da Vinci [9]).

Besides being probably associated with its development, Binswanger immediately perceives the importance of this doctrine - relatively belated. Indeed, narcissism is, as we have seen, a primary stage in the development of the psychic apparatus. As such, its deregulation gives rise to serious disorders which fall within the field of psychosis, precisely the one with which Binswanger is concerned as a matter of priority. Let us remember: the more original a disorder, the more it leaves deep, lasting and, often, indelible traces on the developed psyche of the "adult". The origin remains, she from whom everything comes. We could also take as an example disorders related to orality (anorexia...)

Freud, moreover, laid down his cards and published, in 1917, in his *Introduction to psychoanalysis*, a text which clearly affirmed the link between narcissism and psychosis. Compared to that of 1914, the difference is that it is now a question of libido "of the ego" and no longer of a libido on the body. Self-love is not quite the same as homosexual love (which can let the difference of the object fully subsist)... The reasoning is simple: the strong identity between the loving and beloved subjects leads to an overestimation of the ego through the formation of an ideal ego (role of secondary narcissism: parents idealize their child by projecting on him all kinds of dreams that they have not been able to satisfy for themselves), to an exclusive appropriation of the loved object, the primary form of which will be jealousy and if it grows deeper - in the face of resistance or the inaccessibility of the other but above all, in front of fear/shame/despair inspired by his own tendency - in the certainty of being persecuted (paranoia, at the time qualified as paraphrenia) or, conversely, of being loved in a delusional mode (erotomania). This is the crucible of the circulation between love and hate, so characteristic of the schizophrenic (ambivalence). The perfect illustration of the process is provided by the Schreber case (related by Schreber himself and completed with the deep commentaries by Freud and J. Lacan in *Seminaire*, III).

Why then the skepticism of Binswanger? Precisely because the whole Freudian demonstration aims to show that repression is the result of the drive. What makes it possible to affirm it? The fact that Freud slips without any justification from the normal to the pathological. He does not dare to reveal the central point: the father is never there enough to stop the process. Freud lifts the corner of the veil on the unsaid of something which must remain silent anyway because it is, in fact, anything but natural.

There is therefore a form of irony in this benoît remark in the Letter of January 7, 1920 addressed to Freud by Binswanger: "*The little that you have said about jealousy has all the same infinitely more value than what 'we have been able to say it elsewhere (...) because it is precisely jealousy that seems to me to be able to give us the deepest*

understanding of psychic life, both normal and pathological." Indeed, to this date, Freud only published "Psychoanalytische Bemerkungen über einen autobioraphisch beschriebenen Fall von Paranoïa (Dementia paranoïdes)" in the *Jahrbuch* of 1911.

He would later develop his analysis, also related to anality, in *The Ellen West Case*, a borderline personality disorder before the letter, which revolves around the defenses developed against homosexuality and the recovery of a work of working-through by the disease itself (the patient can only be cured when dead and can only die when cured).

4. Relationship between psychoanalysis and psychiatry

As we have seen, both men seek to enrich psychiatric care. They agree on its insufficiency. Yet the diagnosis about the nature of this insufficiency differs.

For Freud, this insufficiency stems from the fact that psychiatry dilutes the etiology of disorders into a benevolent generality (which he identifies, sometimes, with philosophy):

- because she does not observe meticulously enough:

  "Psychoanalysis has roughly the same relationship with psychiatry as histology has with anatomy; one studies the external forms of organs, the other the tissues and the basic parts of which these organs are made." [6]

- because it favors a heredity which intervenes like a Deus ex machina and especially scotomizes the fact that " there is family and family " and that, sometimes, the family itself can be pathogenic:

  "Why is the content of delirium in our case precisely jealousy?[4] *(...) Here we would like to lend an ear to the psychiatrist, but it is here that he leaves us in the lurch (...) He will search in the family history of this woman and will give us the answer: delusions arise in people in whose family similar mental disorders have occurred on several occasions. If this woman developed a delusional idea, it was because she was disposed to it by hereditary transmission."*

And Freud concludes that both disciplines are complementary... For Binswanger, more radical, psychiatry squarely misses the patient, his illness:

> *"By the development of our psychiatric task, we deviate more and more from the concrete reality of the psychological person. Two paths are open to us:*
>
> - *a conception of the soul and the mental organism.*
> - *a conception of neurophysiological relationships.*
>
> *Now, it must be admitted that these two conceptions have no immediate relation to this concrete reality which we call the psychological person. These are detours on the person-to-person route".* [10]

[4] *Id.* Freud has just described in a woman a case of extreme jealousy which is in fact explained by a repressed fondness for her son-in-law.

It is therefore necessary to modify not the approach of the disorder but that of the patient and to recontextualize the evil in the becoming of the subject, even to make it a lever for healing:

"Illness is a moment in the patient's life history" and again: *"Illness is the expression of the normal course of life"* [5].

However, for Binswanger, ambitious in the ends but too modest in the means, this mutation of psychiatry can only occur by way of internal growth while for Freud, it must proceed to the definitive importation of an external form which it is originally lacking.

For Freud, psychiatry is sick. Sick of his silences and his procrastination. For Binswanger, it is stationed at a functional stage which keeps the patient in the shade, it prevents him (and prevents itself) from growing. Time is requested, more time:

"Freud, he wrote, *always underestimated the difference in structure between the two disciplines... and imagined my role as mediator too easily..." (id.)*

Controversy on the nature of the libido and the drive, contestation on the omnipotence of the id and in particular on a self-sufficient structure of the Ucs which generates both the forces which create and unite and those which destroy and disperse: these are the main stumbling blocks between the Binswangerian and Freudian approaches, approaches which, let us repeat, will diverge even more after the death of the Viennese master. However, beyond this divergence, and even the radical separation represented by the death of Freud, it is clear that the medical collaboration between the two men remains intact.

5. Clinical experience and therapeutic practice

Both men in fact agree on a capital point: because the etiology resides in the patient, the cure can itself come only from him:

"*We can certainly understand what happened to the patient,"* Freud notes, *"but we have no way of making the patient himself understand it."*

Of course, we are still far from any notion of working-through, but with the recognition of transference and counter-transference, the alchemy that is established between patient and therapist appears to be the key to real progress. Now this key is practice which alone can provide it.

5.1 The scope of the psychoanalytic method

"My conviction as to the exceptional therapeutic efficacy of psychoanalysis "in appropriate cases" has in no way been affected by this criticism", writes Binswanger in his *Memories* [5].

He will admit later that, of the eighty patients housed in his establishment, only twenty are in analysis, most of the time those for whom he cares directly (the clinic has five to six doctors).

The question which arises here is that of knowing for which cases Binswanger reserves an analytical treatment, that is to say those to which the application of the analytical grid leaves the hope of a real therapeutic success.

5.1.1 The problem of semiology

The first question is that of the symptom and its interpretation. As we have seen, the status of the sign and of the language, not only spoken but symptomatic, is

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not the same according to the systems. For Binswanger, the question of the "crazy sense" also arises in a deficient language configuration.[5]

But the question is also to know what, "in" the analyst, interprets. Freud of course, with reference to the mechanisms of transference and countertransference, warns Binswanger against the idea that, in order to better understand the analysand, it would be necessary to involve his own unconscious. But for Binswanger, this restriction, if it is the pledge of scientific objectivity, hinders the establishment of co-routing between doctor and patient towards a common world, the ultimate goal of "therapy" and of "infinite" healing.

He wrote to Freud[6]: *"You must admit all the same that there is a unitary mental predisposition common to all men and that if this predisposition works without being hindered, "understanding" is established by itself. But precisely this "of itself" is problematic for me.* And Freud replies: *"My proposal to appreciate the analysand's Ucs as a receiver was formulated in a modest and rationalistic sense, but I know that it conceals important problems".*

This depersonalization (or deindividualization) of the Ucs will be at the origin of a recourse, first as a security then as a surety, to the resources of the hermeneutics of Schleiermacher or Dilthey to found a kind of co- analyst-analyzer hermeneutics, a solution that Binswanger preferred to the Jungian one of a collective unconscious.

But Binswanger's universalizing approach is already like the prodrome of a dissolution of the concept of Ucs as part of a patient's own life story.

5.1.2 Neuroses

When the disorder manifests a deregulation of the course of the libido by a defense mechanism whose the ego, an intact ego but which perceives itself as threatened, is both the stake and the agent, recourse to the analytical approach appears as fully legitimate. According to Binswanger, it is here that psychoanalysis has demonstrated its undeniable effectiveness. But in all their protocols, Freud as well as Binswanger remain essentially pragmatists: *"Freud is and remains the conscientious explorer of nature, who does not say more than experience gives him".*

Starting from the theme of female jealousy, we have, in an earlier article,[7] tried to show from a clinical case how the Binswangerian doctrine is established as a simple extension of the Freudian doctrine.

In Freudian doctrine, jealousy, that is to say the delusional construction of the desire of the other in relation to a third party, is interpreted first of all as a defense mechanism in relation to one's own (unacknowledged) desire. We can refer here to the text of the conference on "Psychoanalysis and psychiatry" (1915), subsequently integrated into the *Introduction to psychoanalysis* and to: "On the transformations of the drives, particularly in anal eroticism", published in 1928 in the *Revue française de psychanalyse*, II. The case cited by Freud is that of a woman who suspects her husband's infidelity when in fact she herself desires her son-in-law.

[5] To stay as close as possible to the truth here, we must recognize that Freud admitted: *"In schizophrenia, it is the predominance of the word relation over the thing relation which gives the symptom its surprising character" Métapsychology*, The Unconscious, VII, The recognition of the Ucs. But he adds: *"This investment represents the first of the attempts at restitution or cure thereby excluding a virtually pathogenic character of language."*

[6] Letter of February 15, 1925. Freud's response arrives - belatedly - in Nov. 22.

[7] This is the case of Ellen West, a case of anorexia, later reclassified as schizophrenia. The article entitled "Freud and Binswanger" appeared in the *Swiss Archives of Neurology and Psychiatry*, I, 2016.

In a second step, the man is identified with the penis, a penis which one wishes, in a regressive and exclusive mode, to keep permanently.

Later, Freud established a link between jealousy (and any form of possessive love) and anal eroticism directly related to the containment of feces. The anal stage is a stage where certain primitive features of love take shape (retaining it and giving it, the risk of detachment from oneself, of loss of the loved object ...).

Finally, as we have seen, he will extend this doctrine to the genesis of psychoses through his doctrine of narcissism.

Except on the ultimate development which aims to link homosexual anal eroticism to the constitution of a narcissistic, jealous or melancholic and potentially paranoid ego, Binswanger shows himself, on all these questions, in agreement with the Freudian interpretation. However, based on his own clinical experience, sometimes shared with Freud (the case of J. v. T. mentioned in the 1910 correspondence or that of Mme F, mentioned in the 1912 correspondence - two cases of repressed homosexuality -), sometimes isolated - that of the Ellen West case - he developed his own theory at that time. Thus in Ellen West, being-in-the-world is first of all being-in-body. However, this body is perceived as a round body, isomorphic to the earth, while it is moreover structured around the void and the hole of the anal orifice but also of the mout and therefore the reverse of the terrestrial world, a ball of matter enveloped in the celestial void. This is the "crazy meaning", all woven of metaphor, that must be deciphered in order to understand Ellen, in particular her doctrine of oral then anal fertilization, her anorexia - as a rejection of the "lie" (no concealment or projection therefore here) - and finally, her suicide as a return to the void and to the hole of the grave from which will perhaps take place another, quite another germination (passion for gardening). We find also this mouth-anus system at Louis Wolfson (*Le Schizo et les langues*, Paris, Gallimard, 2006).

As we can see, the pathogenesis here is structured by something much more than an excessive defense mechanism which would lead to the dissimulation (by projection for example as was the case in the Freudian interpretation) of a repressed libido. On the contrary, it is about revealing and showing. We encounter a similar mechanism in Jürg Zünd, when he manifests - through the wearing of thick coats in the middle of summer or of a suspensorium - in his pathological fear of making the erection visible, that there is, precisely, nothing to hide. Faced with the indecipherable darkness of the drive journey: the blinding light of the human condition.

But in passing, we can clearly see that Binswanger left the framework provided by the psychoanalytic grid: it is precisely the whole condition of man that constitutes the mainspring of neurosis, its "knot", insofar as this condition is not contradictory, by the fact of internal struggles between two orders of drive, but radically incomprehensible. It is the world which lodges in the sign of contradiction, neurosis is only a way of saying it: *"Anality in the psychoanalytic sense is the fragment of a global world of the hole, that is - that is to say a fragment of the carnal part of the proper world"* [11]. It no longer refers, therefore, to a type of repressed pleasure or even allowing to escape, as a passive structure, from a psychosis by a semi-identification with the woman-mother, it refers to a global conception of being-in the world.

Here is announced the project of an anthropology, medical if you will, philosophical if you prefer, to rethink the whole of the psychiatry of neuroses or, for cases like that of Ellen, this which will become borderline personality disorder (Binswanger will speak, in 1921, of *schizophrenia "simplex"*).

5.1.3 The case of psychoses

However, if this enlargement severely relativizes the framework of the Freudian analysis, it does not affect its therapeutic efficacy. It is not the same in the field of

psychoses. Apparently, there are at least, for the psychoanalyst, two entries in this field: the sexual and the infantile. However, this turns out to be insufficient.

The Freudian analysis, as we have seen, is in fact based on the conflict between the libido and the ego, a marked conflict, Binswanger will note, by the personalization and dramatization (of psychic instances).[8] But it is precisely this notion of me which, in psychosis, is missing.

The therapeutic strategy in Freud consists in reinforcing the ego even if, in order to do this, he must recognize the presence and the strength, at its borders, of an Ucs who, ceaselessly, contests them. But when we approach the field of psychosis, this ego purely and simply evaporates.

"In the region of what really gave, Binswanger notes, *we do not meet any me! What astonishment when we then see what is given in a unique way, for example the drives (...) becoming metaphysical, "mythological" or psychological elements building an ego"* [12].

Of course, Freud is not far from reaching a similar conclusion when he speaks of a narcissistic involution of the ego or what amounts to the same thing, of a *"libido which does not seek a new object but withdraws into the ego"* [2], an ego which in the end does not manage to build itself because it remains trapped in the ego of the first figure of attachment. But, here again, the risk of misunderstanding is great because if, for Binswanger, psychosis in fact expresses the absence of the ego, this message must in some way be interpreted positively, and not as a confiscation by the libido or by a mother-world.

Let us take the example of Jürg Zünd, subject to "all phobias" and an "apparent delirium of reference" [11]. He has built a world-project in which at any moment a break in balance can occur, in particular a contraction of space which, suddenly, brings my body closer to other bodies in a violent or even fractal fashion. Where the psychoanalyst would see an etiolation of the ego or, to use a term used by Binswanger himself, a "shrinking" of the ego in the face of a hypertrophied world, Binswanger is content to describe this world-project as the very one. Which *constitutes* Jürg Zünd.

Admittedly, Jürg Zünd has a libido, a sexuality (distancing from women of modest extraction) and this sexuality is indeed the object of a singular treatment since it must be, at the same time, carefully hidden. and openly exhibited. But it is only a language intended to show the veiling of Being - or to reveal its abscondity and this starting from the zero point where space expands/contracts: the body.

It would be the same with Lola Voss, in her delirium of persecution [11]: for Lola Voss it is not a question of rebuilding an ego involved in the rejection of contact with the other but of re- "worlding",[9] with the help of the practitioner, even if she populates her new world-project with ambushed assassins who watch or stalk her relentlessly.

The reconstitution of an ego "master of the house" can in this case be of no help. In reality, it is the ego and the individuation and subjectivation processes that it induces which is pathogenic. Absolutely pathogenic. We must stick to being-in-the-world and its sharing: *"The distinction between existential analysis and psychopathology concerns the* who *of being-in-the-world"* [10].

We then understand that the famous concept of nostrity, which some have considered sometimes foreign to Daseinsanalyse and to the psychiatric doctrine of

[8] This observation results from the numerous notes reporting on the progress of volume II of the *Einführung in die allgemeine Psychologie*, volume it seems almost entirely written but never published and to this day lost.

[9] This neologism tries to translate the specific term of "welten" which remains outside of the idea of creation but of an opening projected of the Dasein (M. Heidegger, *DerUrsprung des Kunstswerkes (1936)).*

Biswanger, is, in reality and in every respect, a psychiatric concept. It has nothing to do with an We which would be born from the meeting between two self-consciousnesses even if, in the texts and in particular in the *Grundformen*, Binswanger often uses both terms by giving them an equivalent meaning. It is the original structure of Dasein like *Mitsein (being-with)* and only the return to it, in and through illness, can "heal".

It is therefore not wrong to say that the thought of the ego evolved in Binswanger, passing from the contestation of an instinctual origin (with a stiffening in the Kantian transcendental I), previously mentioned, to its pure and simple negation in a no less original nostrity. This second position, however untenable in therapeutic terms (faced with the risk of transference, the patient-doctor distance must remain) will itself crumble in recent years and *Wahn (Delirium)* (1965), for example, restores, after the long Heideggerian detour, the hypothesis of a husserlian transcendental ego.

But Freud also evolves and his thought, especially that of psychosis, marks if not a rapprochement with Binswanger's thought, at least the taking into account of his preoccupation. Thus the reciprocal influence of the two thoughts appears more and more clearly.

5.2 The hospital

In terms of practice, Binswanger has a space that Freud does not have, never will have: an establishment. Because the institution is also, and perhaps first of all, a space.

Freud has a particular conception of the establishment: it is first and foremost a place located outside of time and social space and as such allowing to escape the multiple constraints of social life. This idea, however, will gradually fade in the face of the dilution that the practice of analysis undergoes in institutional settings.

On the other hand, Freud integrates this place into the psychoanalytic economy: "It is only by the union of analysis and prohibition (contrary constraint) that one can arrive at something in her (a common patient). I very much regret that at the time, I only had the first means; the second can probably only be applied in an establishment."[10]

This approach betrays, once again, a fundamental position: psychoses, in their very gravity, only express a deeper repression, a more implacable censorship, which the subject imposes on himself, in phase with a repressive device of social or ethical nature. It cannot refer to a positioning of the subject in his relation to the world: whether or not it is the place of a decisive choice between madness and reason, whether it is it or not that decides, in the last place, the mode of approach of the patient and even if, sometimes, one can find that Binswanger assigns a function of escape to him, the philosophy remains the underground stake of the debate between the two men.

6. Philosophy: reason to keep or... reason, fast!...?

Freud, a meticulous explorer of the Ucs, strives never to go beyond the framework of clinical experience and suddenly finds himself constrained to remain in a doctor-patient relationship based on a verbal exchange and, one could almost say fact of the absence of a possible recourse to an establishment, not symptomal [13].

[10] Letter of Freud to Binswanger of April 27, 1922.

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Binswanger, for his part, enjoys the possibility of resorting to restraint but suddenly also takes the measure of its possible failure. For instance, the teaching of the Ellen West case and her suicide (1921) holds a capital place here in the abandonment of a "teleology of cure" but also the success of restraint, in its "relative" maintenance. We can refer to the case of the young girl suffering, at the time of her period, from hiccups and difficulty in breathing and who was cured by "sudden compression of the trachea" ("Über die Psychothérapie"). Binswanger is based on philosophy to think about the disease, the being-man of the patient (but also the being-sick of man) in his relationship to being-in-the-world and intone differently all his medical practice, including psychoanalytic treatment. If, moreover, as Freud claims, the doctor is not a philosopher, the patient, at least as a potential decision-maker of his cure, can be.

He summarizes:

"The central concept of psychoanalysis is absolutely not that of illness but that of health" (with, Binswanger notes below, a "restitutio ad integrum") [13].

6.1 The concept of philosophy

During the first meetings, Binswanger is struck by Freud's apparent lack of appetite for philosophy: *"It was interesting for me to see what weak philosophical needs Freud had"* [11]. During his third visit, the Master will go so far as to confide to him that philosophy is, in his eyes, only a *"sublimation of repressed sexual impulses" (ibid.).*

This statement is not reserved for the Bellevue psychiatrist. In the Preface that he gives to Theodor Reik's work, *The Ritual, psychoanalysis of religious rites* (1919), we find, for example, this disconcerting statement: *"The delusional representations of the paranoid reveal a deep kinship with the systems of our philosophers."*

Ironically, Freud, when asked for his references, evokes the comics of Wilhelm Busch, in particular the series of Tobias Knopp in which the philistinism of the German bourgeois is denounced, and of Max and Moritz, the story of two rascals who terrorize their village, torture and pilfer the chickens, disembowel the bags of grain to end up … in mash for the ducks, crushed under the millstone of a mill. Freud placed Busch albums in his waiting room. There are a few anti-Semitic (irreligious) passages.

However, little by little, here again the gaze changes. First of all, there is a slip by Freud who qualifies the Ucs as a "metapsychical" phenomenon (as we say metaphysical) *(ibid.)* Then:

"I discovered to my own surprise, that Freud had an authentic philosophical vein" (ibid.), affirmation which will come to corroborate, of course, the series of the last published works.

In the register of philosophy, Freud, in fact, read and read a lot "in his young years" (*dixit* Freud) for example, about religion, Feuerbach and about Ucs, Lipps (cf. the *Letter to Fliess*, cited above). His frequent references to primitive life are based on the most recent developments in anthropology, such as those of Morgan and Frazer.

6.2 Role of phenomenology and fundamental ontology

Henceforth, Binswanger considers himself empowered to research what are, precisely, the foundations of Freudian anthropology, what conception of man presides over his reflection. It is precisely this analysis that we find in the speech given in Vienna on the occasion of Freud's eightieth birthday (1936). Freud will not

attend but will say that he was "happily surprised" by it. This discourse is centered on the notion of *homo natura* which refers to a certain form of determinist naturalism [14, 15], which would have the effect of reducing the body to being only an economy of instinctual flow and epistemically, of removing it from its subjectivity by reifying it excessively to transform it into a pure object of analysis.

In spite of this epistemic monism which serves as a basis for his reflection, Freud remains aware of what he is advancing with the Ucs towards a blind spot in humanity - in the sense of being-man. In the account of his second visit, Binswanger notes: *"Freud asserts that just as Kant postulated the thing in itself behind appearance, he [Freud] postulated, behind the conscious accessible to our experience, the unconscious which can never be a direct object of experience".* But, he comments, *"one cannot learn anything from the thing in oneself apart from its existence whereas, by the conscience, one can learn a lot of things about the Ucs"* [5]. It does not say how one can know the existence of the thing in oneself without knowing anything about it, even if, already, the notion of presence and its possible deduction from an absence, are outlined here.

Anyway, Binswanger will continue his path towards philosophy: "*Over the years I had to recognize that the essential scientific and philosophical bases were lacking*"*(ibid.)*. What are the consequences? Is this what, gradually, will separate the two men, on the theoretical level of course?

Let us first see the approach of the Ucs where Binswanger collects the fruit of his efforts to erase the role of self-awareness, of the ego.

"By turning to phenomenology and existential analysis," writes Binswanger, *"the problem of the Ucs has changed for me; it widened and deepened insofar as it was always less opposed to the "conscious" - opposition which still largely determines it in psychoanalysis (...) Insofar as in the existential analytics of Heidegger - unlike Sartre - we start precisely not from the conscious but from being-present, as being-in-the-world, this opposition was erased for me" (ibid)*.

As in Heidegger, the notion of body will gradually fade away in favor of a bodily existing (a *leiben*, a "corporealize", a "corporéiser"), just as the world will unravel in favor of a "worldize", a "mondéiser" ("das weltet", Heidegger will say) in the same way, we see, over time, does the Ucs become, in Binswanger's eyes, a mode of being-in-the-world among others, a "way" of being-there (only the word "there" will allow him to save in this process the specificity of the body as a source of a space stretching its "directions of meaning").

Mode of presence of Dasein which, let us repeat, can also affect a collective "way" (one could here draw a parallel between the evolution of Freud towards the collective problematic of the Ucs and the Jungian discovery of a collective Ucs. Binswanger who keeps a distance between the two tries to federate them - at least doctrinally - through the notion of Dasein).

But the effort of synthesis and, it is true, his somewhat obsessive concern for continuity, will take Binswanger further, especially after the disappearance of the master, substitute for a father who died precociously, helped him to deploy resources of his system: *"Beyond psychology, psychoanalysis and biology, we must begin with an anthropology"(ibid.).*

Perhaps we will be criticized for forcing the line here? But many elements militate in this direction. The most convincing remains the procrastination which surrounds the publication - which ends in a non-publication - of the second volume of the *Einführung in die allgemeine Psychologie*, which was, after having been updated, in the first volume (1922), the philosophical roots of classical psychiatry, showing how psychoanalysis revolutionizes the psychiatric field while remaining faithful to it.

The planned summary is[11]:

1. Freud's psychology and the building of the person (genetics)

   Definition of psychic (meaning and signifiance) and Cs (Lipps, Freud)

2. Psychic conflict: personification of instances and dramatization

3. Social and instinctual

7. Interpretation (in connection with Schleiermacher and Dilthey)

But Binswanger does not publish, will never publish this work because already, in his eyes, this work is "outdated". In particular, the notion of interpretation which Freud made, applied to dreams, the royal way of access to the Ucs, can, according to him, be understood only from hermeneutics. Once again, it is not the dream but the whole existing which requires, according to a dynamic process, to be - indefinitely – deciphered. We find in the *Journal*: *"Read the Psychology... of Schleiermacher with the feeling of finding myself on known and sure ground. His work on Hermeneutics confirms to me that my book must begin with hermeneutics and be articulated with it"*. But such an introduction to psychoanalysis immediately deported Freud to the territory of the religious (Schleiermacher is first of all a theologian). Binswanger therefore preferred, with good reason, to abstain.

In "Freud and the constitution of psychiatry" [16], Binswanger goes back to the ethical code of psychiatry as formulated by Griesinger and he writes: *"With Freud, man is no longer simply a living organism but an essence of life dying its life and living its death (...) disease is no longer a disturbance coming from the outside or the inside but the expression of the "normal" course of life on the way to death"*. This affirmation seems to recognize in psychoanalysis a theoretical overhang (linked to the superposition of infantile development and the successive repressions that accompany it) but it is immediately strongly qualified*: "That we are lived by the powers of life, it is not there only one aspect of the truth; the other aspect is that we determine it as our destiny. And only these two aspects manage to embrace the problem of meaning and madness, of delirium" (ibid.).*

This is the second message that Binswanger sends to psychoanalysis: freedom can only initiate a process of healing (that is to say of recognition of its destiny) from the moment its role in the morbid process has been recognized - and in that this process cannot be totally disavowed (doctrine inspired by the Heideggerian one of "freedom at the bottom"). To disavow the original choice of madness would deprive the patient of all continuity in his being-in-the-world, in subjective terms: to suppress the self-confidence which guarantees "healing". In this process, another recognition will have to take place: that madness itself has its roots in the exercise of this freedom because, if I am free, I am "only that".

7.1 The religious

A disagreement remains between the two thoughts but not between the two thinkers. Here again, however, it will not be identified in the same way.

[11] *Journal*, II, p. 50–57. Quoted in *Correspondance Freud-Binswanger, 1908–1938*, Paris, Calmann-Lévy, 1995. A series of notes based on the examination of Binswanger's Journal enlightens the progression of the work, pp. 216, 218, 221, 238, 245 and 257.

For Freud, this disagreement is primarily of religious origin. Neither of the two men, in fact, wishes to go beyond this problematic and here, the question of the biological (in génétic sense) reappears because neither Freud – who evolves on that point - nor Binswanger grants it any primacy. Regarding Judaism for example, Freud writes: "*There is only one serious fact: Semites and Aryans (or anti-Semites) that I wanted to bring to a fusion within psychoanalysis, separate again like oil and water*"[12].

Now Freud is irreligious: *"I still accept, at a pinch, a good binge with alcohol, but a binge without alcohol …"* he wrote after Binswanger had questioned him on this question.[13] In fact, here again, Freud never ceases to take up this question in his last texts, about the writing of which, moreover, he never ceases to talk to his colleague. *The Future of an Illusion*, which appeared in 1927, links the religious phenomenon to the need for relief linked to the anguish of the child. For his part, Binswanger revamps his concept of religion which he finally resolves, under the influence of Martin Buber, into a religion of the I-You relation (*Grundformen*, I) and of which he finally announces the definitive substitution:

"In place of theology should come psychology; instead of Salvation, health; instead of suffering, the symptom; in place of the pastor, the doctor" [5].

Thus he pays homage, post-mortem certainly but sincere and fair, to the one who, beyond the misunderstandings, has never ceased to keep hope and confidence in his young teammate.

8. Conclusion

In the management of the relationship, what was Freud's mistake in the end? If there was an error, it was to consider that Binswanger embodied, in the circle he had drawn around him, classical psychiatry, an institutional psychiatry, well established on its foundations but also, at the same time, misoneist and pusillanimous. and which closed its doors to its new approach to care, an approach whose legitimacy was constantly reinforced by clinical experience.

But this was an approach in terms of influence struggle and Binswanger expected something else, something else he could not find despite the rich exchanges of information between the two men, for example on the development of their respective families, strangely similar it must be admitted.

What Freud did not understand is that in fact, Binswanger was in turn trying to get out of this same psychiatry and that therefore, in fact, he could not embody it, striving on his side. to purge it of a representation of the man whom he judged devaluing, sterile, but in exchange for which Freud offered nothing that met his expectations. It was, however, in Freud that Binswanger had to find the most relevant elements in order to think at new expense the fundamental forms of human presence and define the new modalities of his knowledge, Freud for his part drawing from his exchanges with his colleague a fertile questioning.

"Man, the master of Kreuzlingen wrote in *Memories [5], takes too much at his ease with being-present. One of the forms of this lightness is neurosis, it is a life suspended in the moment, opaque to itself. The world of such a present-being oppressed by the moment is the wish for fate, the inordinate imagination. In the face of this, creation stands in truth, as the existence of Freud exemplarily reveals to us. Only a productive man can endure the painful life".*

Dr. Philippe VEYSSET.

[12] Letter from Freud to Binswanger of July 29, 1912.

[13] Lettre from Freud to Binswanger of April 2, 1928.

Conflict of interest

There's no conflict of interests.

Author details

Philippe Veysset
Archives Husserl (Ecole Normale Supérieure), Paris, France

*Address all correspondence to: veysset@noos.fr

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Section 3

Psychoanalysis and Pioneering

Chapter 4

Is the Death Instinct Silent or Clinically Relevant? From Freud's Concept of a Silent Death Instinct to Understanding Its Clinical Manifestations

Gertraud Diem-Wille

Abstract

When Freud introduced his concept of the death instinct in *Beyond the Pleasure Principle* (1920) he solved three theoretical problems which could not be explained by the one drive theory: masochism, repetition compulsion and the negative therapeutic reaction. The concept of two inherently opposed instincts remained one of the most controversial parts of Freud's theory. For Melanie Klein, Freud's idea of the death instinct was a powerful instrument in solving her greatest problems of integrating her clinical evidence of an earlier, very harsh superego. In Freud's account, the superego was the manifestation at birth of the death instinct operating in destructiveness towards the person, as he had argued. In this way, Klein put – as Hinshelwood claims – clinical "flesh on the bones of Freud's theory of the death instinct." I will describe the development of Freud's theory and how this was elaborated by Klein and her followers Bion, Esther Bick, Segal and Rosenfeld. With three clinical vignettes--from an Infant Observation, a child analysis and an adult analysis--the clinical use of the concept will be illustrated.

Keywords: death instinct, clinical evidence of the death instinct, Freud's dual instinct theory, repetition compulsion, negative transference

1. Introduction

1.1 Freud

Freud's model of the mind is a dynamic one- that is, it understands the mind as being in constant movement and conflict between impulses arising in one area, along with defenses against these impulses [1, 2]. He developed three models, adjusting them to his clinical material according to his understanding of therapeutic work with his patients as research into the human mind – "psychic apparatus," as he first called it.

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2. The topographical model of the mind

Freud's first model was based on repression, which occurs when thoughts or wishes are not acceptable to the thinker, who accordingly learns to repress them from consciousness. The Unconscious – usually metaphorically conceived of as a *deeper* layer of the mind – tries to bring these repressed ideas back to light. The repressed induces dreams, is used in jokes, causes "Freudian slips" and forgetting things, elucidate creative ideas, and sets the formation of a symptom in motion. The return of the repressed is described by Freud in "The Psychopathology of Everyday Life" [3] in a surprising and convincing way.

3. The structural model

Freud then began to conceptualize the mind less as composed in layers – his favorite archeological metaphor of the analyst who is searching for a buried culture – than as consisting of agencies or structures: the ego, the super-ego and the id. The id corresponds roughly with much of what had previously been encompassed by the concept of the Unconscious. It can be regarded as an area containing the primitive instinctual elements, dominated by the pleasure principle and functioning according to the primary process, as in dreams. The ego constitutes the rational part of the mind which is in touch with the external world, and which tries to mediate between our desires and reality so that we can stop insisting on the impossible, and settle for what is – thus postponing the fulfillment of impulses. The superego is a fiercely irrational, unreasonable half-instinctual force granting only partial gratification or even suppresses instinctual impulses. Sandler stats, that ... it developed as a sort of internal stratum or residue of the child's early conflicts in relation to his parents..., ([4], p. 27). The idea that we act according to the pleasure principle was difficult to maintain when Freud discovered the repetition impulse, the negative therapeutic reaction and masochism/sadism.

The concept of the death instinct, Thanatos, and the life instinct, Eros, as two basic instincts.

Freud introduced the idea of the death instinct in 1920 in "Beyond the Pleasure Principle" as a biological drive and expands on its psychological significance in 1923 in "The Ego and the Id." "His view is that under the influence of the life instinct some of the death instinct is deflected out in the form of an attack on the object," writes Spillius et al. in the *New Dictionary of Kleinian Thought* ([5], p. 298). Freud writes:

> *Besides the instinct to preserve living substance and to join in into ever larger units, there must exist another, contrary instinct seeking to dissolve those units and to bring them back to their primeval inorganic state. That is to say, as well as Eros there was an instinct to death. The phenomena of life could be explained from the concurrent or mutually opposing action of these two instincts ... a portion of the (death) instinct is diverted towards the external world and comes to light as an instinct of aggressiveness and destructiveness. In this way the instinct itself could be pressed into the service of Eros, in that the organism was destroying some other thing, animated or inanimate instead of destroying its own self. Conversely, any restriction of its aggressiveness directed outwards would be bound to increase the self-destruction, which is in any case proceeding. At the same time one can suspect from this example that the two kinds of instinct seldom – perhaps never – appear in isolation from each other, but are alloyed with each other in varying and very different proportions and so become unrecognizable to our judgment." ([6], p. 119)*

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Freud distinguishes between two very general tendencies which he referred to as *libido* or *Eros,* on the one hand, and *aggression,* which he formulated in terms of the *death instinct (Thanatos)*, on the other. Libido or Eros is manifested in all processes, both physiological and psychological, that impel towards synthesis. Freud assumed that the death instinct remains within and some of the remaining death instinct is fused with the libido to form sexual masochism. Other fusions occur, resulting for example in 'moral masochism', but some remain unfused as 'primal sadism' ([7], p. 164) when cruel action give pleasure and lust. The death instinct or the Nirvana principle constitutes the most fundamental aspects of instinctual life: To return to an earlier state, the absolute "Ruhe des Anorganischen" (repose of the inorganic) ([8], p. 102) and is therefore an economical principle reducing energy to zero/nil; it is silent operating in the background and cannot be seen in the clinical material.

With the concept of the death instinct, Freud managed to solve three riddles and explain the contradictions regarding the pleasure principal and Libido as a source of primal strength.

First, some consideration needed to be given to the phenomena of the "Compulsion to Repeat'-- repeating unconsciously unpleasant experiences from earlier life instead of overcoming them – "an irrepressible force which is independent of the pleasure principle" … "a fundamental tendency of every living being to return to the inorganic state." ([8], p. 102). The repetition compulsion occurs in a patient's transference relationship to the analyst, patterns of thinking, feeling, and behaving from earlier life – which can be painful and distressing. The repetition compulsion also occurs outside analysis, in normal as well as in pathological relationships – Freud likened it to the death instinct in his later writing.

The second riddle to be solved was the concept of sado-masochism and hate. From the very beginning, it seemed impossible to Freud that hate could be derived, metapsychologically speaking, from the sexual instinct.

The third riddle was the negative therapeutic reaction, which means that some patients reacted badly to analytic interpretations even after they had acknowledged their accuracy. "One begins by regarding this as a defiance and as an attempt to prove their superiority to the physician, but later one comes to take a deeper and juster view. One becomes convinced, not only that such people cannot endure any praise or appreciation (of the analyst GDW) but that they react inversely to the progress of the treatment…. A temporary suspension of the symptoms produces in them for the time being am exacerbation of their illness; they get worse during the treatment instead of better." ([9], p. 49) Freud explained the negative therapeutic reaction in two ways: as an expression of unconscious guilt or as an envious attack on the analyst.

The death instinct is perhaps Freud's most controversial assumption. It has been severely criticized by both psychoanalysts and others and highly appreciated and further developed by Herbert Rosenfeld [10], Betty Joseph [11] and Hanna Segal [12]- the object relation school. This was difficult for the psychanalytic community to accept, because Freud thought that the manifestation of the death instinct was silent, meaning that one could not investigate it in clinical material as they two instincts are fused and defused with the result that it can be observed in a number of different mental states, e.g. a fear of falling apart and disintegration, self-destructiveness, destructiveness, envy, sadism ([5], p. 298).

4. Melanie Klein's and Bion's concept of the death instinct

Melanie Klein used Freud's view of the death instinct and his concept of incorporated objects to give a theoretical basis to her clinical observations in work with small children and their harsh and punitive attitudes towards themselves and

towards figures of their imagination. "Klein considers the harsh internal figure to be the introjected hostile mother whose hostility towards the child stem from the sadistic phantasies attacks that the child made of her … this hostile internal mother as an early version of the superego." ([5], p. 299).

Klein assumes that from the very beginning the baby has a core-ego and an inner conflict between Eros and Thanatos. In the International Journal of Psychoanalysis celebrating its 100th anniversary a chapter is dedicated to "Repletion and the Death Drive" (2019). Freud's concept of the death instinct is seen by Blass as a "new view on the tie between narcissism and death, which is relevant for the Kleinian view of it" ([13], p. 1294). She connects Freud's concept of a fundamentally opposed instincts, from which all emotions, sensations, desires, and activities derive as affirmation of Klein's concept of the paranoid/schizoid and depressive position. Rosenfeld [14], Bion and Segal [12, 15] suggest an anti-object relational force with destructive attacks on the self and the object.

The first year of life is of enormous significant for the baby as the basic elements of the physical and psychic development are laid. One can it compare with building the foundations of a house and of equal importance for its stability and structure. The child needs another living and caring object to perceive the real world, being aware of the difference between inner and outer sensations: although Klein assumes a core-ego since birth the baby's thinking, and its relationship to the parents are all evolving out of raw, unintegrated feelings and perceptions. The parents or caregivers must help the infant as it copes with its raw, primitive and archaic feelings and somatic perceptions. They need to be perceptive how the baby feels and what it needs. In the first three months, a "social birth" follows the baby's physical birth, where it builds a relationship to the world via its relationship to its mother or caregiver (primary object). The infant can establish elements of structure and inner order if its mother succeeds in containing and understanding its raw fears and giving it back to the baby describing them with words so that the baby can introject them. Winnicott calls this ability of the mother "Primary maternal preoccupation," Stern speaks of "mother and baby being in harmony or in tune" Bion speaks of a special ability which he calls "Reverie" meaning the capacity to sense what is going on in the infant [16].

In Bions's words, the baby needs a mother/container in order to be emotionally touched; this mother/container takes in the baby's projected raw sensory data, which Bion calls "Beta-Elements," and transforms them into "alpha" elements which the child can introject and begin to think ([16], p. 110–119). Esther Bick compares the infant with an astronaut who has been shot into space without a spacesuit. She thinks the baby fears that it will either disintegrate or die. Especially this observation when a baby is undressed and start trembling is considered as expression of this basic fear ([17], p. 296).

By internalizing its mother's caring and containment the baby develops a positive core in its psyche, a "good inner object," which remains a secure inner base. The loving, emotional care, the infant's first encounters with chaotic forces remain embedded in the deepest levels of its personality, constituting a "psychotic core" that is normally subordinated by positive experiences. If, on the other hand the baby finds his despair and misery are not received, it leaves him with what Bion calls "nameless dread," unspecified, unthinkable thoughts which have continually to be expelled/projected into others ([18], p. 7).

Now I shall describe a vignette from an observation of an infant and its mother following the Tavistock model developed by Esher Bick (the observation follows Esther Bick's method, developed at the Tavistock Clinic) [17, 19]. As the method is well known, I shall simply add that the observation is for one hour and notes are not made until after the observation. The observation is written up, presented

and discussed in a weekly seminar of 4–5 participants led by a psychoanalytically trained clinician who is experienced in Infant Observation. The observation of Felix and his parents was video-recorded by Barnett [20] for research and video purposes. As he was born on a Sunday, she called him "Sunday child."

5. Felix, twelve days old

Felix's mother is 36 years old. The father brings Felix into the bathroom to his mother, who greets them both and takes Felix into her arms. After she has undressed him, she places him in the ready prepared baby bathtub.

> *Felix is just a few days old, he has his eyes closed and his hands are balled into fists. He cries in a high voice and is truly unhappy. In the background we hear father's voice making calming comments. It seems his words are addressed at the mother to calm her more than it does Felix. When the mother starts washing Felix's belly with soap, she talks to him saying: "Oh Felix, oh dear!" But his crying becomes even louder as the mother lifts him out of the water to wash his bottom, and he rather screams. The mother remains calm, continuing the washing and says, "Shhh", then turns him round and washes the back holding him securely under his arms. When the mother lifts him out of the water, his crying is of penetrating and frantic volume. He turns his head back and force, stretching it backwards with increasingly louder screams. When the mother turns him around again, lowering him into the water, and slowly dribbles water over his belly and chest his crying stops. Now the mother moves her head close to his and talks to him quietly about how comfortable and warm the water is,. "Do you like the water now a bit, Felix?" she asks. For the first time Felix opens his eyes a little and looks into his mother's eyes while she smiles at him. "Well, you see, it's OK. Look what I am doing now," she says, and begins to move him very gently back and forth in the water. He clearly enjoys it and has both eyes open, his fingers are relaxed. … When he seems to enjoy it even more Felix closes his eyes and lets himself drift. (Description of the scene in the film by [20])*

In this short observation in the film we can see how Felix needs protection from the outside world, how he presumably is anxious about falling apart without boundaries. His crying puts his mother under pressure, as if she had done something harmful to him and she is out of touch even stressed. The mother puts her head closer to his and talks with him in a calming way as the father's voice is calming and encouraging her. With the help of his mother's soothing voice Felix' anxiety diminishes and he can actually enjoy slowly moving about in the water. We see that both parents (the father is in the background) comprehend Felix's unhappiness and des pair, talk with him, and help him to cope with these overwhelming feelings and anxieties. We see an example of what Bion calls "containment" – a mental and emotional process – where the mother perceives the baby's raw, disjointed impulses, digests them and then gives them back to Felix in a modified way. He might even remember the floating feeling in the uterus. When the mother responds in this way – being in "harmony" as Daniel Stern called it - Felix experiences his mother responding to his needs and mirroring his feelings; a communication between mother and Felix was established and will further develop day by day. Empirical infant research has made video-supported analyses of the complex tactile and verbal early communication between mother and baby in order to understand the emotional development and the learning of patterns of social interaction [21].

6. Child analytic case

Now I want to describe a vignette from an analysis of a 3 ½ year old boy, whom I call Patrick[1]:

Patrick's parents came to see me first as a family in a parent-infant psychotherapy for 5 sessions. It was clear that Patrick needed a longer therapy so the parents agreed to an analysis for him. He had nightmares and they had to wake him up to help him stop crying. He had fits of rage, and was an outsider in his playgroup. In the transference to his analyst the same patterns that he has towards his parents are developing. Patrick's parents had not described any unusual experiences with their child although he woke up almost every night screaming and in panic. With Patrick it was his kindergarten teacher who drew the parents' attention to his emotional difficulties.

In the first assessment Patrick showed me his chaotic inner world, turning the playroom with cruel destructiveness and sadistic pleasure into a messy world in which he had no hope of making himself understood. For me, the analyst, it felt like a massive attack and I could hardly believe what I saw when he destroyed the brand new colored pencils. He deliberately and violently broke off the tips of the pencils, then throwing them around the room, then stamping on them. I tried to transform his projections of beta-elements into words, to show him how desperate he was and that he wanted to push these unbearable sensations into me. I suggested to him that he wanted to show me how easy it was to make useless broken pencils out of the beautiful new pencils and that he perhaps felt broken himself. When he continued I told him that he was convinced that I would turn away from him and he would not be allowed to come back. Then he stopped. As if accidently, he touched my legs with his body by standing close to me, leaned trustingly on my leg. I told him that this was his way of showing me that he felt touched by my words. He looked into my eyes so that I added, "Now you feel understood" and told him that he could come three times a week and he nodded.

Now I shall describe a session at the beginning of Patrick's second year of analysis, where the fine structure concealed behind his apparently unmotivated destructivity and the special quality of Patrick's relationship to his father became visible. Here some vignettes from a therapy session:

> *First, we were two fishermen with fishing rods fishing small fish. Then he became aggressive demanding that I shout at him: "Dirty Patrick, he makes his pants dirty". When he was unable to do something, he said "crap"; when he gets excited, he quickly had to use the toilet. Later he played to be the little baby who needs his pants to be changed; he wanted me to be the father who did it. With enthusiasm he was the little baby, lying down (wanted to pull down his trousers what I stopped) I should say: "Lift your bottom", what he did pretending to put some paper towel under him as if it was a diaper. Then I should put him to bed as his father did. When I asked: "Where is the mother", he answered: "She is dead". After a few moments – in the middle of the night he climbed out of the bed. I was told as his father I should find him, shout furiously at him and beat him. This game was very intense. Patrick was not contend with my simulation of beating with without touching him. He became excited, took my hand and showed me how to do it saying: "You have to hit me hard, much harder!" Since I did not do this, instead expressing verbally how I (as his father) was furious with him, he began to hit himself with his own hand. "That's how to do it," he said.*

[1] The case of Patrick is described in full in my book *The Early Years of Life* [22].

In his play Patrick shows the persecutory quality of his paranoid-schizoid feelings. He put me in the position of the sadistic father who clearly wants this punishment and denigration of his son. The pleasure of both of them was clear. Both of them are stuck in these intense sado-masochistic struggles. He wants to repeat them again and again. For the analyst, it is difficult and shocking to feel these feelings in him/her in the countertransference – but as Bion said: "If you cannot bear the heat, refrain from the kitchen." ([23], p. 40). In many sessions, Patrick demonstrated how successfully he upset both himself and his father, drawing his father into his cruel fights. He is part of a couple consisting of a man and a by – a homosexual couple - who were bound together in a pleasurable yet intimately cruel way. The child was in control: Patrick knew he could provoke his father into a state of extreme rage and complete helplessness. That was very satisfactory for him. My aim was to make him aware that he was the active agent in this. Or Patrick could provoke his father by doing the opposite of what his father wanted him to do, or pretended not to hear him. In a role play, he showed me how he could do this. He wanted me – as the child - to come and told me I had to pretend not to hear him. Then he as his father got furious and screamed "Don't you hear me?". I could feel the power to provoke him to get so furious. Sometimes he sat in the car ready to drive off, and I as the child was supposed to hesitate to get into the car. Then he really seemed about to drive away to threaten me as the child. I then had to scream in horror and run after him in panic. He showed he enjoyed this power game even to the extent of manipulating his father into acts of violence.

In the following discussion with the parents, the father said to me that he had asked his wife to take care of all disciplinary questions with their son. Patrick now loved to build houses with his sister, including the father in the role either of mailman or policeman. The parents were impressed by all the changes in Patrick, fits of rage had completely vanished; in kindergarten, in his play he showed more ideas and fantasies than the other children. It was important to allow him to continue his analysis to stabilize his inner development. He now loved to go to the playgroup. Visibly moved, Patrick's mother described how he could talk about his feelings. She also could discuss and explain what decisions she and his father had made. Once Patrick came to her, put his arms around her neck and said, "Mommy, I love you"; that was the first time this had happened. He could also part from her without crying.

In these brief vignettes, I tried to show how useful Bion's concept of container-contained is. Elements of destructiveness and jealousy emerged continually with Patrick, where he spat on me, tried to kick me or to tear the spectacles from my face in a fury and wanted to break them. I always had to be on guard to protect him and myself. However, he gained more control over his aggressive impulses. When I could understand his changing moods and connect them with his experience, he got softer and more sensitive; he even put his head in my lap as if he wanted to go back into mother's belly. As a very distressed child he showed his inner conflict in a concrete way, often wanting me actually to perform the same cruel punishment and mockery as he provoked his father into doing. Patrick learned from emotionally experiencing his analyst able to take in his projections, suffer their impact, and put them into words. Pursuing the emotional truth even in very disturbing areas – as clinically visible expression of the death instinct – enabled him to acquire a knowledge that enriched his personality.

The advantage of working with children as young like Patrick is that they still show their aggression in a concrete and obvious way and show by their reactions whether they take in the interpretation of the analyst – stopping the destruction as soon as they feel understood. Then, it is not any longer necessary to show their aggression in this way and we can explore the deeper anxiety behind it. With adult

patients the aggressive wishes are mostly covered by a strong defense system. Now I shall show how an adult patient struggled to accept his aggressive and murderous wishes which were so vividly manifested in his dreams. In the session we observe the same struggle against understanding in the inner world of the patient, who attempts this with all means- mainly by massive projective identification, pushing these feelings into another person, his ex-wife or his analyst. In one dream he shows his aggressive side which is envious of his new baby.

7. Vignette from an analysis from an adult patient Mr. a

Mr. A is a 46 year old psychologist. He is in his second analysis because his first analyst was too ill to continue (Mr. A. still idealizes him). He is married for the second time to a warm and caring woman. He has a son with his first wife, a two-years-old son with the second wife and just got a new baby. He behaves as if he has no idea about insight, projects his omnipotent destructiveness into me and judges me from a moral high-ground. Often my words are felt as an attack and then he complains, he dismisses a shared responsibility. If I try to show him the situation of his ex-wife he accuses me of feminism--taking sides with women against men. Sometimes when he exposes his vulnerability and dependency he feels exposed. When I stick to the rules of time and fee – although I reduce it twice to make it possible for him to continue – he can accept them as strict but fair.

When his third son is born he is relieved and happy. It was a spontaneous birth, he is a robust baby—not as delicate as the second one. At the end of one session he says: “Maybe Prof (meaning me) was correct that the baby could develop well because I brought my aggression into the sessions.” On the following day he relates a dream he had after mentioning the worries he had had at birth of his baby because the umbilical cord was during the delivery around the baby’s neck, making a knot so that it could not be tightened.

P: (After a pause) I had a dream which is connected with yesterday’s session, I think. (He says it in a superior way as if he knew everything already and lets me know he does not need me to understand his dream). (Before he starts to tell the dream he goes into the details of yesterday’s session for 15 minutes. I become irritated and impatient but do not interrupt him). I felt abandoned by you.

> *The dream is in my analytic session, you and I are there but the room is much bigger-- 5 to 6 times as large (my room is rather spacious), really big and with impressive furniture. I come in and then I see at the entrance two workers decorating the entrance. A baby is lying on the floor. One man passes by and kicks the baby a bit without doing it on purpose. Then the second worker puts his large foot on the baby and presses hard, he even turns his foot on the baby’s chest. I go to him and shake him and pull him away telling him what he is doing. Then I walk in. It is very beautiful and impressive. I am speaking and suddenly you get up and without an explanation you leave the room. I do not know what the matter is. Then Dr R. walks in and sits down on your chair and listens. I talk until the end of the session. (Pause)*

(He continues) I understand the dream that it is my wish that you leave because you did not understand me yesterday and I felt abandoned. Dr. R. has always impressed me and a colleague who is in analysis with him spoke quite freely on how he is as an analyst.

A: You come in and tell me that you felt bad yesterday, abandoned by me and today you told me how tired you are not getting enough sleep ... In your dream you show how you feel what you cannot feel during daytime--that you feel left behind

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by me, by your wife who is looking and breastfeeding the baby. In the dream I go away and let you be with another analyst who does not refer to the early years of life (Dr R is a Lacanian psychoanalyst).

P: That I am jealous of M (new baby) I cannot feel in any way. What I can see is how much work it is to look after two small children and my mother had 5 children, my older brother, my older sister, myself and the new baby and while she was breastfeeding she became pregnant with the youngest sister. When I spoke with my mother on the phone she said we should look after the older son so that he does not feel rejected. Respect! She can think about the older boy.

A: You are glad that I can look at the child part of you who feels rejected and left behind as your mother does. And can we have space to think about the two workers and what they are doing with the baby, first by accident and then on purpose hurting the baby?

P: Naturally this must be a part of me, I am the dreamer like the director of the dream, the author. I know this although I cannot feel any aggression towards the new baby M. I use this understanding when I interpret my patients' dreams and it is very helpful.

A: It is easier to see it with other people than when it happens inside you.

P: Yesterday I observed how my wife's attention was distracted when she breastfed M … I told her: Do not you realize that M is disturbed? She said: It's just a minute.

A: You describe how sensitive you are and how you can understand M's situation and another part of you feels terribly neglected and angry. And can you allow this angry part to become visible?

P: **You** are talking about murderous impulses!

A: When you say: 'I am talking about murderous impulses and not you' you show that you find it is difficult to keep in mind that it is your dream. You dreamed about the two workers putting their feet on the baby – expressing your unconscious phantasies. When you are awake you are shocked and want to push this aggressive impulses into me - you want me to be the author of this aggression: they should not show your wishes.

P: Sometimes I do feel tired because of this constant feeding at night. My wife told me to sleep in another room to be able to get some sleep, because I cannot help her with the breastfeeding anyway. But I cannot do it, I stay with her.

A: You cannot leave the two of them alone--you want to control what they are doing at night.

P: (laughs) To control them – well, I let them be together the whole day when I am working.

A: When you laugh you allow yourself to take the analytic breast and take my words in and it calms you. Now you felt understood and this dreaming part is glad to have been listened to.

P: I feel different now.

The **following day** he says: "Yesterday the session made me feel calm"…

A: Yesterday's session you felt you could get in touch with me for a moment and accepted what I offered. The part of you who wants to know and expresses himself in dreams, wanting to understand yourself, opens up sometimes.

P: Indeed-- and this only happens after a session with fighting, conflict and arguments. The image I was thinking about was the picture of the two workers who kicked the baby hard. I do not feel anything corresponding to it, no jealousy, and no anger towards M. In the dream I took the first one on the shoulders and pushed him away. It is hard to believe that this worker is really a part of me, of my wishes. But when I work with my patients and know how to interpret it I have to accept it in my dream as well even if I cannot feel anything.

A: You can see how difficult it is for you to see these primitive and murderous wishes in you. In your dream you were successful in pushing the two workers aside so we can assume that inside you have a part which does not to let you really harm the baby. This only happens in your fantasy and not in reality and this calms you. And you said how good it felt to be able to talk about it with me and that I can accept it.

8. Discussion

The patient struggles to accept his unconscious murderous wishes expressed in his dream by the two aggressive workers and his jealousy against his new baby M. which he also dearly loves. He is used to dealing with his aggression and destructiveness by projecting it into others, first into his first wife when he blames her for the problems of their son. He allowed his former wife to be sadistic and did not stand up against her. He could not manage it. He cannot think about his contribution to the problems of the marriage or the difficulties of his first son. Now he is married to a warm and sensitive woman. Mostly he holds on to his pompous superiority. In the session I described, he is enormously agitated and reveals himself in a puzzling way: he has a new baby but behind his pride and joy of having a new baby he feels burdened by it--it is another mouth to feed. He is struggling to earn the money for his living and his analysis. Does he know that he is fighting against the wall struggling with the new baby? Can he differentiate between his outer and inner reality? He himself is a disturbed baby with unbearable guilt. He cannot see how difficult he is and he successfully projects his anger and alarm into his analyst – I have the murderous thoughts, not he, he says at first. He can use his ability sometimes in a touching way, it is a real struggle for him to get to know himself. He makes slow progress. In his dream his aggressive fantasies are expressed by the two men. Can he accept this part of him? Sometimes he can use his abilities and have insights. He has to put himself in my position – he as the therapist – then he can understand the meaning of the dream. He has to gain enough perspective to distance himself from his dream in order to see his destructive part.

He has got this lovely baby – strong and robust – but it stirred up so much rage and hatred. He felt he did not get sufficient understanding and support/containment from his mother and hardly can accept my help. He wants to see himself in a manic way as somebody who makes wonderful babies and is hardly able to accept himself as a disturbed man desperately clinging to his analyst/mother. As a baby he could not let go of the breast so his mother – after she had another baby – also allowed him to drink from her breast until the age of three, which made him feel guilty.

He chose me as his analyst because he thinks I am a Kleinian who is not afraid to see and deal with his primitive, dark sides, understanding the "two strong workers" as parts of him. Finally he can integrate his love with his aggressive, jealous feelings. When I asked his permission to use his dream in this paper he answered, that he remembers this dream vividly and also his strong resistance against my interpretations. He used the opportunity to tell me how well his life and his family had developed and thanked me for his analysis "which had been the greatest enrichment in my life and professional development."

9. Final remarks

In these three vignettes, it becomes clear how variously the death instinct is manifested—with Felix' Infant Observation as woeful cries, with fingers pressed into fists that we understand as the fear of disintegration or of death; with Patrick, chaos rules his interior life, with his great fear erupting in attacks of screaming or weeping

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as well as nightmares, and his destructivity and cruelty projected "successfully "onto his father—to whom he has established a sadomasochistic relationship which excludes the mother, who is "dead" in role playing; with Mr. A., his murderous rage is pushed onto the analyst through massive projective identification and he remains as a nice, protective father of his baby. The analytic work consists in containing these unbearable impulses, digesting them emotionally and mentally and rendering them discussable. Felix' mother was able to take up the feelings projected into her through "reverie" (Bion) or "primary motherhood," to digest them and ameliorate his fears through her loving attention, so that Felix could ultimately move about happily in the water. Only through recognizing his psychic pain could Patrick work through his painful experiences and establish a loving relationship to his parents, integrating his aggressive impulses and using them to develop a new independence. His mother takes Patrick seriously now as an independent child, whose various wishes she can understand and help him to deal with and solve conflicts without manipulating him. Mr. A can recognize his "baby part" and finally integrate it. His massive jealousy and competition from his childhood is worked through transference to his analytic "siblings," so that his great emotionality and care for his family and his patients become visible. We can see how this competition can be constructively solved or lived by his youngest son M., for whom Mr. A is a loving father. At the age of two, M starts a special ritual: he leads his father and his older brother in the morning to the front door as if he were the head of the house and says goodbye to them there, remaining as the man of the house behind with his mother. He then proceeds to be a very good, loving child all morning. The following little episode shows how well not only Mr. A but his son managed to integrate contradictory feelings:

> *When M. was four years old, his father came home one evening, greeted him and asked what he was building with his blocks. The son replied enthusiastically: a castle for himself and for his mother. The father, who had never been convinced by the concept of an oedipal phase, reflected and then asked where he would live then. The son thought seriously for quite a while and said: "In the garden there is a little house—you can live there! "This constitutes a mature emotional accomplishment, granting the beloved father and rival a space.*

Hannah Segal describes the conflict between the life and death instincts and the way the individual can respond:

> *"One, to seek satisfaction for the needs; that is life-promoting and leads to object seeking, love, and eventually object concern. The other is the drive to annihilate: the need to annihilate the perceiving experiencing self, as well as anything that is perceived." ([12], p. 18)*

Mr. A was able, after working through his repressed aggressions, experiences of humiliation and feelings of abandonment—which he projected onto others—to use his life-affirming object relations in his family and profession.

There is still a controversial discussion concerning its philosophical status and its clinical usefulness. Michael Feldman however points out – and I agree – "that the gratification of this psychological drive does not lie in the annihilation of the perceiving and experiencing self, or indeed in literal death or annihilation. On the contrary, what is often clinically more compelling is the extent to which certain patients, rather than seeking to annihilate their perceiving selves, attack and distort their capacities for perception and judgement…The aim seems to be largely, but not entirely, to eliminate anything that gives rise to admiration, dependence, rivalry and, particularly envy." ([24], p. 97f).

When the patient then holds on to illness and suffering, Feldman considers this not to be a derivative or compromise, "fused" or "bound" with the life instinct, but "a direct expression of a primary destructive drive towards the self and the others" (p. 98). The means to achieve this are distorting the words of the analyst, a fascination in omnipotent destructiveness, distorting the meaning and value of the analytic work. A shift can be brought through the patient becoming more able to acknowledge and tolerate his awareness of his own hatred and anger. Mr. A can hardly agree to an interpretation but does think about it between the sessions and bring it back as his own insight in the next session. The occurrence of curiosity and the wish to know and understand himself indicates a movement towards the life instinct. As Bion puts it in his article "On arrogance" (Bion 1957, p. 86–92) "when pride appears within an individual who is dominated by the life instinct, pride becomes self-respect, but if the death instinct predominates pride then becomes arrogance. These arrogant dismissals of the analyst's interpretations can undermine the ability to care for the patient and stir up anger in the analyst. Brenman describes his dealing with the angry countertransference by reminding himself "how ill the patient is" ([25], p. 105). If we discover with the patient how he became the character he/she is and why he behaves in this particular way, being a victim of deprivation, loneliness and deal with the emotional pain of his earlier traumata he can recover the good inner object. "The good object … is the combines (intimate) relationship of the infant and mother and the subsequent development extending to other object relationships, in which persons give personal meaning to each other… nothing can be meaningful without this foundation," says Brenman [25].

Additional information

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Author details

Gertraud Diem-Wille
University of Klagenfurt, Austria

*Address all correspondence to: gertraud.diem-wille@aau.at

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Chapter 5

From the Shadow to the Light: Navigating Life as a Mother with a History of Substance Use and Parenting a Child Healing from Early Childhood Trauma

Linda M. Perez, Suzi E. Desmond and Cheryl J. Sundheim

Abstract

We report on an innovative in-patient residential recovery program that serves as a model for those who treat low-income women with substance use and psychiatric problems and their children. The case discussed details the psychotherapeutic treatment of a mother and child that was carried out within the protection of the program's seeking safety, trauma informed model of care. The treatment demonstrates the sensitive care that is needed when working with a young child with a history of early childhood trauma and the favorable ways that holding the mother in mind freed her to be emotionally available to her son. In this situation, the therapist provided an emotionally-attuned interpersonal therapeutic relationship and created features of safety in the environment that helped the child develop an emerging reorganized protective structure to safely explore his fears. The mother and child can follow a course of recovery from traumatic experiences within the context of favorable conditions, thereby interrupting the intergenerational dynamics of early relational trauma.

Keywords: seeking safety trauma informed care, psychoneurobiological treatment approach, early relational trauma, establish safety and trusting relationships

1. Introduction

1.1 Seeking safety, trauma informed model of care

Trauma has been described as the single most important public health challenge [1] that is too often silenced and unacknowledged for its significant prevalence and devastating impact in our public dialog [2]. In the United States drug overdose deaths rose from 38,329 in 2010 to 70,237 in 2017 followed by a decrease to 67,367 in 2018. Narcotics or opioids (mainly fentanyl or fentanyl analogs) are the main cause of drug overdose deaths followed by methamphetamine and cocaine psychostimulants. Additional overdose deaths involving benzodiazepines or antidepressants are mainly due to those ingested with synthetic opioids. Women account for 33% of these statistics (National Institute on Drug Abuse, 2020).

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These alarming data override the importance of the 19.7 million American teenagers and adults, age 12 years and older, who battle daily with a substance use disorder, many of whom struggle with alcohol consumption and both a substance use and mental health disorder [3]. Nor do they account for the effects of the loss of a loved one or the consequences of intergenerational trauma as children inherit extreme stress that is passed on through the caregiving system. Such a predisposition interfaces with life's pressures that trigger emotional and psychological problems in future generations [4].

The purpose of this article is to report on an innovative in-patient residential recovery program that serves as a model for those who treat low-income women with substance use and psychiatric problems and their children. The majority are mothers who are pregnant, parenting infants in the first 3 years of life, or reunifying with older children who are in the foster care system. We find that long-term substance use or dependency is associated with mental health challenges, and no matter which came first, successful treatment demands that one addresses both simultaneously. The recovery program combines a ***seeking safety, trauma-informed model of care*** [5] to enable the women to meet their most urgent clinical need to establish safety and develop trusting relationships and secure attachments with their children, thereby, interrupting the intergenerational dynamics of early relational trauma.

There is a deepened understanding that infants and young children, who live in impoverished environments exacerbated by substance use and maternal psychopathology, are at risk for adverse developmental outcomes. Given their capacity for mutuality and reciprocal relationships, the form of psychotherapeutic treatment most compatible with this view is performed within the context of the dyad and the attachment relationship. Attention is focused on the complex interactions that occur between mother and child in a relational context [6–8]. This type of relationship-based clinical practice is appropriate when difficult circumstances such as parental substance use or depression, chronic stress, or child constitutional or developmental characteristics interfere with the formation of a secure attachment [9].

Clinical questions that are germane to this paper are: How does a psychoneurobiological approach, which draws from psychoanalytic, attachment, polyvagal, and neurobiological theories present an integrated way of interrupting the intergenerational effects of trauma that are passed on to future generations? How does our understanding of polyvagal theory enhance the clinical situation within the safety of a trauma informed model of care that emphasizes secure base therapeutic relationships?

2. Theoretical perspectives

2.1 The psychoanalytic approach and attachment theory understanding

Ainsworth's [10] characteristic of the attachment figure as a secure base from which to explore the protection of a therapeutic relationship and to develop new models of trust resonates with a seeking-safety, trauma-informed model of care. Developing a secure base in psychotherapy is as important as it is for children's development and humans' long-term need for safety. In the therapeutic process, protection includes social-emotional security through the therapist's ongoing regulation of the individual's affective state, often calming through emotional availability [7, 11]. Therapeutic co-regulation signifies regulation of co-adaptive processes at the level of behavior, physiology, and representation [12–14].

Bowlby [15] places a steady relationship between an individual and a familiar person on a level of biological importance secondary to the maintenance of physiological stable states. He proposes, "the regulatory systems that maintain a steady relationship between an individual and his familiar environment can be regarded as an outer ring of life-maintaining systems complementary to the inner ring of systems that maintain physiologic homeostasis" ([16], p. 150). Therapeutic co-regulation is a critical component of a homeostatic response to stress and is a treatment strategy that can be used to regulate the individual's internal state [12, 14].

The aim of a secure base model of psychotherapy is to facilitate the mother's understanding and reconstruction of a protected internal working model at a representational level [12]. Another purpose is to enable the mother to form a healthy bond with her offspring. Bowlby [12] recognized that when treating mothers with insecure states of mind with respect to internal working models of attachment, it is essential for the therapist to remain fully present and emotionally attuned to the mother so that a special kind of well-being can flow from the dependable emotional connection. That deep and loyal attachment with the mother is profoundly individually empowering and emotionally regulating. The mother now feels a special bond with the therapist emerge, assisting her to reciprocate emotionally attuned and regulated interactions with her child.

2.2 The attachment relationship and its regulatory function

The goal of the attachment system is for the infant to obtain proximity to the attachment figure, especially in time of stress, fear, or danger (real or perceived). A mutual goal of the caregiving system is to provide proximity, safety, and sensitive care for the child. Protection includes not only physical protection but social-emotional protection as well, through ongoing regulation of the infant's emotional state by way of emotional availability and attunement [7, 11].

Attachment research shows that mothers with unresolved trauma and who demonstrate fearful or dissociative behavior tend to have children with a disorganized attachment pattern [17, 18]. For these children the mother is a source of fear rather than a source of comfort. In situations where the children feel a threat to their own survival, they will have great difficulty regulating arousal. For these children the mother is a source of fear rather than a source of comfort. As a result, they lose the benefits of the attachment relationship and psychobiological attunement and homeostatic regulation that should serve to reduce their fear.

Schore [19] claims that attachment relationships are important beyond the provision of a sense of safety and protection. He goes on to say that prolonged psychobiological transactions associated with a stressful caregiving relationship impair the initial formation of the stress response system in enduring ways. His view supports the notion that poor psychobiological regulation is a traumatic stress that produces long-term changes in biological systems. Continuous suboptimal caregiving generates hormonal reactions that promote an impaired hypoactive or hyperactive stress response that is mediated through the hypothalamic-pituitary-adrenal (HPA) axis [20]. If the HPA axis is repeatedly activated, stress-response mechanisms are set a high level of reactivity that both stimulates the release of cortisol and is sustained by it [21, 22].

2.3 Polyvagal theory

Polyvagal theory offers another view of homeostatic regulation of the autonomic nervous system in which to understand and treat fear and arousal. Porges [13] coined the word neuroception to describe how the nervous system is genetically

wired to detect safety, danger, or threat, well below the level of conscious awareness, when it is challenged by the environment. At the point where fear activates biochemical changes in the autonomic nervous system, the brain reacts defensively to social challenges through either sympathetic hyperarousal or parasympathetic dissociation. The most usual response to a perceived threat is a fight or flight response as a form of self-protection. If the environment does not respond, the individual moves through a dissociative continuum, initially becoming compliant and immobile (freezing), followed by surrender and dissociation. This hypoarousal cool down on top of high arousal leads to a collapse in the parasympathetic nervous system.

Porges [13] asserts that a traumatic event can impair an individual's neuroception and leave in its wake misidentification with a sense of safety, danger or threat. In his view, prosody of voice and facial expressions are important features of safety that set-in motion the process of reducing stress and calming the limbic system, thereby, allowing an individual to participate in social engagement. Emotionally-attuned interactions that are presented face to face with kind gestures and a soothing tone rather than signs of disapproval more reliably mitigate fear and interrupt defensive behaviors [13]. These favorable exchanges have the potential to regulate autonomic state so that an individual can explore feeling safe within the protection of a therapeutic relationship and fully engage in therapy. At the same time, it is important to create added features of safety in the environment through predictable expectations and schedules.

2.4 Neurobehavioral descriptions of trauma

Trauma has been described as the single most important public health challenge [1]. The neuroscientific world recognizes that trauma is imprinted on the body leaving the individual overaroused and fearful even after an event ceases to exist [1, 13]. When everyday occurrences activate intense fear, the fear becomes conditioned and deeply entrenched, biasing the nervous system towards overarousal. Fewer environmental stimuli are now required to reactivate early fear [23, 24]. The therapeutic aim is to reduce the stimulation of the neural pathways that communicate fear and stress in the hope that these pathways may eventually fade through lack of use [23].

Living in fear distorts sensory perceptions and it gives rise to disproportionate, atypical development of the parts of the right brain associated with decoding facial expressions and reading threatening social cues. At the same time there is underdevelopment of the parts of the right brain governing self-control. In some cases, the brain seeks extreme sensory experiences and pursues incautious unsafe exploration. In other cases, brain function and behavior become rigidly organized around an aversion to stimulation and exploration.

Trauma produces high levels of the catecholamines epinephrine, norepinephrine, and dopamine. Activation of these neurotransmitters correlates with anxiety, hyperarousal, and hypervigilance [24]. As such, individuals have trouble inhibiting negative impulses and thus operate under the influence of the lower, impulsive brainstem, literally acting without thinking.

This same fear activates biochemical changes in the autonomic nervous system [19, 23–25]. It is not unusual for people to react neurobiologically and defensively to their fear with a constant fight or flight response or, worse, dissociation. If they stay in a continuous state of dissociation, the neuronal system mediating this response becomes sensitized thus increasing the risk of their developing psychiatric symptoms including depression, anxiety, helplessness, and withdrawal [23].

3. An integrated trauma informed model of care

Those of us who work directly with families living in extraordinarily stressful circumstances confess to the many difficulties inherent in the process. Over the past 35 years our recovery program has treated low-income mothers with substance use and psychiatric problems and their young children in the San Francisco Bay Area. The majority of the women who come to the program have histories of trafficking, poverty, homelessness, incarceration, school failure, and are victims of domestic violence and child abuse.

3.1 Relationship-based intervention

There is a heightened understanding that comprehensive substance use and mental health treatment for the mother must include the young child in the cure [26]. Otherwise, little attention is paid to the adverse developmental threats to children who may be prenatally drug exposed or whose lives are negatively influenced by toxic stress. The trauma-informed in-patient residential recovery program for women and children that we are presenting is founded on the premise that a relationship-based approach acts as a secure source from which the women explore the protection of a therapeutic bond and environment.

This corrective method enables the women to realize safety and develop new models of trust, encourages them to express their ideas in an environment where they are valued, treats their substance use and mental health disorders simultaneously, facilitates emotionally attuned interactions between the mother and child to foster secure attachments, remedies the many deleterious effects that profound stress has on the mother's and the child's nervous system, and interrupts the intergenerational dynamics of early trauma.

A culturally competent and trauma informed recovery team of family therapists, clinical social worker, psychologist, psychiatrist, nurse practitioner, and medical doctor work collaboratively with intake clinicians, substance use counselors, parenting specialist, and child care providers to deliver ethically responsive in-patient substance use, mental health, physical health, onsite therapeutic childcare, and parenting education. This coordinated effort provides a singular opportunity to help the mothers to overcome their addiction and stabilize their mental health while promoting an emotionally healthy mother infant dyad.

The residential treatment program has resources and system-wide procedures in place to identify and treat the women and their children's needs. The assistant executive director oversees the management of treatment programs and recurrent multidisciplinary team meetings strengthen collaboration and coordination among all services and other community support systems. The women receive psychiatric consultation, clinical case management; substance use and mental health counseling; health screenings; nursing advice; and recovery groups plus life skills, seeking safety, and nurturing skills parenting classes; a 14-week Circle of Security attachment training; and interactive playgroups that accentuate dynamic exchanges between the mother and child.

The birth of a constitutionally-compromised prenatally-exposed infant to a mother in recovery is stressful and can overwhelm her. More often, the infants have experienced other complex traumatic stressors and have regulatory problems that plunder the mother's own ability to co-regulate her infant. All mothers admit that it is a struggle to care for an agitated, stressed infant. Even capable mothers may be unable to do so without proper help. The infants and young children at the recovery program get onsite pediatric health care, mother-child psychotherapy, and licensed

therapeutic childcare with mental health consultation, developmental assessment, and early intervention that is focused on prenatal drug exposure and early childhood trauma.

3.2 Toddler with a history of neglect and a disrupted attachment relationship

The following example illustrates the program's therapeutic treatment of a mother with a known history of depression and substance use and her 18-month old male toddler with a noteworthy past of prenatal drug exposure, neglect, a disrupted attachment, and a foster home placement. Early experiences of neglect can create implicit memories that may trigger defensive behavioral reactions if adults try to console the child when feeling threatened [2]. A toddler who has been removed from the mother is likely to suffer from separation distress and problems with the attachment relationship. In turn, the mother may have difficulty regulating her child who is easily disorganized from the effects of the traumatic separation that endangers the attachment bond and that are exacerbated relative to her own mental health challenges. Additionally, it is not unusual for the mother to feel remorseful for failing to get help sooner.

At the early phase of treatment, the mother immediately meets with the psychiatrist to ensure psychiatric stabilization and medication management. The mother and child spend the first week together in the STAR (Services to Accelerate Resilience) program where they meet staff from the adult substance use and mental health recovery program, the family mental health and pediatric clinics, the therapeutic child care, and the family enrichment program. During this initial stage, the staff develops a relationship with the mother and child focusing on their strengths and informally observing their interactions while evaluating their needs. Afterwards, the team members gather at its weekly meeting and clinical supervision to recommend features of safety across all of its programs and to coordinate on-site child referrals to the pediatric clinic and the family mental health treatment program.

At the next phase, interventions are implemented to treat the mother's symptoms of mental distress through ongoing sessions with the substance use and mental health therapist and the clinical case manager. The mother attends daily in-patient recovery groups that focus on her own trauma and substance use history, as well as a Circle of Security attachment training and parenting classes where she is taught knowledge of child development versus child management, how to identify and respond to her child's trauma behaviors, and ways to use emotionally attuned interactions to re-regulate the child's distress.

By now, the child is enrolled in child care and is receiving trauma informed developmental care and assessment, medical and nutritional support, and mental health consultation. Given that the trauma coincides with the child's expectable developmental challenges, interventions focus on supporting new skills, identifying traumatic stress reactions, and recognizing traumatic triggers that lead to stress behaviors. These trauma-informed strategies are incorporated and reinforced in the residential living area by the parenting specialist and a 24-hour staff of substance use counselors. Additionally, the child is seen in the pediatric clinic and referred to the family mental health clinic for mother-child psychotherapy.

4. Mother-child pyschotherapy

Mother-child psychotherapy is a relationship-based clinical practice that is appropriate when the mother is depressed and battling substance use and the

child has a history of traumatic stress that jeopardizes a secure attachment [9]. The therapist's primary objective is to strengthen the attachment relationship between the child and mother and improve developmental outcomes. This clinical approach demonstrates the sensitive care that is needed when working with the dyad and the favorable ways that holding the mother in mind frees her to be emotionally available to the child.

In this kind of psychotherapy, the therapist attends to both the mother's and child's emotions, and to their relationship while considering the mother's mental health and substance use treatment. Essential to this practice is for the therapist to notice and reinforce positive interactions between the mother and child by remaining mindful and emotionally attuned to the mother. This support and attunement will help to alleviate the mother's symptoms of distress so she can be more present and available to help her child organize emotional and intellectual responses necessary to adjust to life stressors.

The psychotherapeutic treatment begins with a guided clinical interview performed by the child psychologist who is a team member of the therapeutic recovery program. The mother talked about her own psychiatric and drug history and how it prevented her from protecting and caring for her child. Now that she is in recovery the mother wanted to get well and attend to her child's needs. The mother disclosed that she was exhausted due to her depression and the child's night terrors that were keeping her awake at night. She discussed how the child is frequently tearful when he is dropped off at the childcare and her inability to comfort him. The mother wanted to know if the therapy could help her understand her son's behavior and whether he would be like other children in the program who seemed less upset. The therapist explained that her child appeared easily disorganized from the effects of early trauma, including separation from her while he was in foster care, but that he could adapt to these stressors with her support and therapeutic intervention.

The psychotherapeutic treatment included the therapist observing the dyad interacting during caregiving and child-centered play, focusing on how the mother engaged her child. The therapist looked for areas of synchronicity and difficulty in their interactions that were influencing their relationship. When the child cried and the mother raised her voice to get his attention and rushed to soothe him, he ran away and hid in a corner of the room, refusing her comfort. When the child did not accept her efforts to console him, the mother perceived this as rejection and became stiff and helpless. The therapist observed a mutually stressed mother-child system that was diminishing the mother's own regulation and ability to co-regulate her son's behavior.

In these moments, the therapist contained the mother's and son's distress by creating a quiet and supportive environment, and by modeling for the mother how to respond in a sensitive way. She encouraged the mother to approach her child more slowly at eye level and use a soothing voice to lower his arousal to an intensity he could tolerate before trying to comfort him. The therapist talked in a reassuring tone that helped to calm and regulate the mother's emotions before explaining that her son's rejection was his way of telling his story and asking for help. In this close context, the mother gained trust in the therapeutic process and revealed her own traumatic history of growing up in the foster care system.

The treatment also included periodic observations of the child in the childcare setting where the therapist worked with the teachers to identify his traumatic stress reactions. The teachers reported that the child was primarily tearful and subdued when he was dropped off in the mornings, that he often hid in the corner of the room and rejected interacting with the teachers or playing with his peers, and that the child was mostly silent except when he became highly aroused and protested if he had to wait his turn during meal times. At naptime, he would resist going to sleep or wake up crying.

5. Therapeutic goals

The therapist formed a clinical impression that the child's early experiences with neglect and a disrupted attachment relationship had created a sensitization where he did not trust that his basic needs would be met. The therapist, in conjunction with the mother, designed a therapeutic plan that consisted of weekly dyad visits for the child and the mother and developmental guidance and consultation with the child care teachers and the parenting specialist. The treatment goals emphasized the importance of a trusting and secure attachment relationship with the mother, offering the child interactive co-regulation, providing supportive transitions from mother to child care, creating features of safety in the classroom and living environments, and alleviating the mother's symptoms of distress.

5.1 Foster a secure mother-child attachment relationship

The mother had difficulty putting her child to sleep in his crib and tolerating his night terrors. She revealed that being unable to soothe him brought up feelings of rejection and doubt as a mother. The therapist assured the mother that her solid commitment to her recovery and mental health treatment, as well as seeking therapeutic and developmental support for her child improve her ability to care for him.

The therapist helped the mother to understand that the birth of a prenatally-exposed infant is stressful for both mother and baby, especially if there is a lack of social support. The therapist clarified that ongoing stress can overwhelm a mother and weaken her ability to care for her baby. If there is a worsening of mental health and substance problems that go untreated, the unintentional consequence can lead to child neglect and a foster home placement.

The therapist explained that young children who experience early trauma see the world as a dangerous place. When your child is avoiding going to sleep and waking up screaming or running away from you, his brain and body are saying that he is scared. His fears are triggered automatically by something that reminded him of a stressful experience. In these moments, your son needs to receive cues that you are physically and emotionally present to keep him safe. He is saying, I am scared, and I want you to support me even when I run away from you. Please approach me slowly and gently, sing softly and tell me I am safe and that you will stay and take care of me.

Together, the therapist and mother listed attachment behaviors that the child used to signal distress. These included crying during separations from the mother to the child care and to his crib, night terrors, and running away and rejecting comfort from her and the teachers. The process of going over these behaviors allowed the mother to reflect on her son and their attachment relationship, and to share her own observations and concerns. The therapist explained that once his attachment needs are consistently met, he would begin to feel secure and start to explore his environment and other social relationships. She reassured the mother that responding sensitively to her son's attachment behaviors would generate a sense of security that he is looking for and the expectation of an available mother in times of upset. The therapist clarified that your child requires your physical presence, even when he runs away from you, to decrease his stress. At this stage of development, he is too young to be able to call upon his mother's image and a mental model of his attachment figure as a form of self-soothing.

5.2 Assist early regulation of basic physiologic functioning

The mother's own mental health challenges and substance use history compromised her ability to regulate her son's sleep pattern. The mother was worried

because she felt helpless when her son resisted going to sleep in his crib or when he woke up screaming during the night. She, herself, was sleep deprived and feared the consequences involved in breaking the program's safe sleep protocol of no bed sharing. She wanted help putting him to sleep in his crib and how to respond to his night terrors.

The therapist explained that sleep is an anxious time of separation for young children, especially if they have a history of being removed from the mother and placed in a foster home. The therapist worked with the mother to create a consistent nighttime routine for placing her child to sleep in his crib and for alleviating his night terrors. It began with a bath to help him relax followed by calming activities such as reading his favorite books. The mother was to quietly hold her son and speak calmly and softly until he showed that he was drowsy and ready to sleep before laying him gently in his crib. She was encouraged to sit by the crib and stay near her child and not leave his side until he was in a deep state. The therapist identified the child's different states of arousal and showed the mother how to regulate his arousal levels by altering the environment and looking for cues that he is tired in order to support a smooth state transition to sleep.

The mother shared with the therapist that she was feeling sleep deprived and asked the therapist to meet with the recovery program's mental health and substance use counselor to incorporate a rest period as part of her daily treatment schedule. The mother also asked the therapist to meet with the child's teachers to reinforce the therapeutic goals in the classroom to ensure that he was getting enough rest during nap time.

The therapist modeled for the teachers how to offer interactive regulatory support to the child when he became highly aroused during stressful periods. It was explained to the teachers that the therapeutic skill from this point of view is to gradually regulate levels of arousal through an interpersonal and emotionally attuned relationship within the context of a supportive environment [27]. The suggested curative aim is to minimize the stimulation of the neural pathways that communicate fear and stress in the hope that these pathways may eventually fade through lack of use [23].

The teachers were asked to create a consistent and predictable nap routine that prepared the child for sleep and to use comfort items for him to have during the transition that would calm and soothe him. They were reminded not to wake him up if he was crying out in his sleep, but rather use a reassuring and soothing voice that lets him know that you are there for him and to remain by his side until he settled. The teachers and parenting specialist recognized that "pressuring" the child to wait to eat during meal times increased his stress. They met with the mother to identify his favorite foods and arranged for small meals and snacks to be available at child care and in residence for him to eat throughout the day and evening.

5.3 Support transition from the mother to child care

The child was subdued and tearful each time the mother left him at the child care. The mother was conflicted over staying to comfort and meet his emotional needs and being late to the recovery program. Some of the time she would leave abruptly due to her own stress reactions, which increased both his and her distress levels. The therapist discussed with the mother that quick departures reinforced his sadness and worked with her and the teacher to implement a consistent and gradual transition plan during morning drop off.

The mother agreed to come to the child care earlier to participate in a pleasurable activity such as reading a book in a quiet area with her child and the teacher. Together, they looked for cues that he was relaxed and adjusted to the classroom before the

mother left for her program. At the time of departure, the teacher assured the child through close proximity and a reassuring voice that he would be cared for until his mother returned to pick him up.

As part of the transition plan, the mother brought his favorite items to the classroom to access during the day to calm and self-soothe. It was explained to the mother that his representational thinking of his attachment figure had not yet emerged and the comfort items, which represented a symbolic image of their relationship, were a form of self-soothing during difficult goodbyes. So, for the child, when his mother moved out of his sight, he felt scared as he perceived that she had vanished. His fear was triggered automatically by the stressful experience of his "mother's disappearance" when he was removed from her and placed in a foster home. It is of significance that traumatized young children are at a heightened risk of perpetuating a fearful state because their immature perceptual system interprets stimuli that even remotely resemble those associated with the trauma as dangerous.

5.4 Create features of safety

An important part of the therapeutic process was to create features of safety in the classroom and the residential environment that reduced the child's fear and protected him from exposure to reminders of past traumatic experiences. The child care teachers and the parenting specialist consulted with the therapist to identify strategies that worked to modulate the child's emotions and their own stress reactions when he would hide in the corner of the room and rejected interacting with them or playing with his peers. In these moments they learned to take deep breaths, practice being mindful and present by pausing and reflecting, and asking each other for support if feeling overwhelmed.

The therapist reinforced the teachers' efforts to implement consistent routines, a predictable daily schedule, visual aids, and an area that provided the child a sense of control. The teachers created a quiet area with pictures of the mother, books, comfort items, and sensory-regulating activities where they could quietly join the child and validate his strong emotions, while mediating pleasurable peer interactions. To reduce his fear response, the teachers were taught to approach the child slowly at eye level and to communicate with a soothing tone and kind face that affirmed his emotions and that guarded against signs of displeasure. They were educated in polyvagal theory, that prosody of voice and favorable face-to-face exchanges have the potential to regulate autonomic state so that young children can socially engage with their caregivers [13]. At the same time, the therapist worked with agency staff to integrate trauma informed practices and features of safety across all programs. The staff's deep affection for the child that grew over time, and was reinforced by the progress that he made, suggested he was feeling safe and trusted his needs were consistently being met.

5.5 Alleviate the mother's symptoms of distress

A mother with a substance use and a psychiatric disorder who is coping with unresolved trauma often cannot be emotionally attuned to her young child without therapeutic support. Notably, during the initial clinical sessions with the dyad, it was necessary for the therapist to alleviate the mother's symptoms of distress and free her to be emotionally available to her son. In these moments, the therapist's own attuned affective state helped organize the mother's mental processes and emotions so that her son could regulate his state through direct connection with the mother. This interactive regulatory process created a deep bond within the triad that reduced the mother's and child's intense arousal. In other words, the mother's

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emotions are regulated by the therapist's compassion and empathy. The child's emotions are now regulated through the mother. When the child calms down the mother also calms and is able to emotionally attune to her child.

In this close therapeutic context, the mother discussed her own trauma history with the therapist. The mother talked about her parents who used drugs and the loneliness she experienced living in a foster home. Now in recovery, she was reconciling the pain of both receiving and passing on the family suffering to her son. The therapist explained that psychological distress from a history of traumatic experiences predisposes individuals to inherit extreme stress and a misidentification with parental suffering [4]. Such a predisposition borders with life's pressures to trigger psychological disorders whose symptoms worsen overtime when healthy coping strategies break down under high stress. If untreated, stress is passed on through generations of children passing on this painful legacy. The therapist's shared affect and willingness to stay connected to the mother during these painful conversations created a safe space and affection between them and enabled the mother to gain trust and fully commit to the therapeutic process.

6. Summary and discussion

The case discussed here details the psychotherapeutic treatment of a mother and child that was carried out within the protection of the residential recovery program's seeking safety, trauma informed model of care [5]. The mother-child psychotherapy demonstrated the sensitive care that was needed when working with a child with a history of neglect and a disrupted attachment relationship and the favorable ways that holding the mother in mind freed her to be emotionally available to her son. There existed evidence that the child's early traumatic experiences had created a sensitization where he did not trust that his basic needs would be met and a mother who was remorseful for not getting help sooner.

Early in the therapeutic process it was vital for the therapist to remain fully present and emotionally attuned to the mother so she could gain trust in the therapeutic relationship and fully engage in the therapy. The mother's attempts to soothe her child caused him to reject her and the mother to become overwhelmed and helpless. The therapist observed a mutually stressed mother-infant system that was diminishing the mother's own regulation and ability to co-regulate her son's behavior. The therapist created a protected therapeutic space and explained that the child's rejection was his way of telling his story and asking for help. The therapist's shared affect and willingness to stay emotionally connected to the mother alleviated her symptoms of distress so she could be emotionally available to her son even in moments when he was outwardly refusing her efforts to comfort him.

The primary questions that guided the therapeutic process asked: How does a psychoneurobiological approach, which draws from psychoanalytic, attachment, polyvagal, and neurobiological theories present an integrated way of interrupting the intergenerational effects of trauma that are passed on to future generations? How does our understanding of polyvagal theory enhance the clinical situation within the safety of a trauma informed model of care that emphasizes secure base therapeutic relationships?

To address these questions, the therapist explained to the mother that young children who experience early trauma see the world as a dangerous place. When your child is avoiding going to sleep and waking up screaming or running away from you, his nervous system is saying that he is scared. His fears are triggered automatically by something that reminded him of a stressful experience. He is saying, "I am scared, and I want you to support me even when I run away from you".

The therapist clarified that his fear overwhelmed him and that he got relief and reduction of his stress through the protection of a secure attachment relationship with his mother. The therapist modeled for the mother how to approach her child slowly and gently at eye level, singing softly and telling him that he is safe and that I will stay and take care of you. According to polyvagal theory, prosody of voice and favorable face-to-face exchanges have the potential to regulate autonomic state so that children can relate to nurturing adults [13].

As part of the psychotherapeutic treatment it was necessary to apply the psychotherapeutic goals and to create features of safety in the classroom and in the residential treatment program. Inquiries that surfaced focused on the child's neurobiological reactions to stress. Does he create the same conditions of compromise in the program staff? Do they have the emotional self-awareness and interactive regulatory capacity to regulate their own behavior and ameliorate the child's distress? To address these questions, special care was taken to explain the child's behavior to the teachers in the classroom and the residential treatment staff.

The therapist clarified that the child's behaviors were a natural response to early traumatic stress and showed the child care teachers and parenting counselor how to regulate the child's distress and attune to his intense emotions using gentle movements, a calm voice, and face-to-face interactions [13]. They were supported for their efforts to stay connected to the child during heightened levels of arousal and for providing a safe and containing environment that affirmed the child's emotions and minimized his fear responses from becoming conditioned. According to Perry et al.'s [23] findings, the therapeutic aim is to reduce the stimulation of the neural pathways that communicate fear and stress in the hope that these pathways may eventually fade through lack of use.

The mother successfully completed the in-patient residential treatment program in 6 months and moved to the program's sober living environment where she and her child resided for one year. The mother recognized that during the transition, her child's separation distress had increased, and it was beginning to take an emotional toll on her. It was essential for the mother to receive individual community mental health and out-patient recovery services and for the child to continue the mother-child psychotherapy and the therapeutic child care. The therapist assured the mother of the progress that she and her child had made in the first 6 months of treatment and that the recent changes showed that they had regressed under the current stress and could adapt to these changes with ongoing therapeutic support.

In the next 6 months of mother-child psychotherapy the therapist worked with the mother and the child care teachers to continue with the strategies that were effective in assisting the child to develop new models of trust. During this phase of treatment, the mother revealed that her confidence to care for her son improved and she was better at regulating her own emotions and meeting his needs. She learned how to prepare nutritional meals in the recovery program and her son was no longer highly aroused around food. He was sleeping throughout the night in his own bed and had made substantial developmental gains, entering childcare ready to play. The mother brightens when talking about their close relationship and the sureness she has gained in caring for him. She believes that her childhood would have turned out differently if her parents had received substance use and therapeutic support.

7. Conclusion

This article represents our clinical work with mothers and young children who suffer extraordinary stress from the effects of substance use and mental health

illness. The mother-infant psychotherapeutic treatment and developmental guidance provided to the mother and the program staff helped to regulate and restructure the child's nervous system. Feeling affirmed and supported, the child developed an emerging reorganized protective structure from which to safely resolve his fears and explore social relationships.

We conclude the mother and young child can follow a course of recovery from early traumatic experiences within the context of favorable conditions, thereby, interrupting the intergenerational dynamics of early relational trauma. A critical variable is staff who serve as a secure base whom the mother and child can trust and who is available to provide interactive regulatory attunement. It was by virtue of the therapist's ability to regulate the mother's and child's dysregulated affective states that they seemed to endure the strain of recovering from substance use and mental health challenges within this particular therapeutic milieu.

Author details

Linda M. Perez[1*], Suzi E. Desmond[1] and Cheryl J. Sundheim[2]

1 Epiphany Center, San Francisco, CA, United States

2 CS Consulting Services, San Francisco Bay Area, CA, United States

*Address all correspondence to: lmperez@mills.edu

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Chapter 6

From the Couch to the Screen: Psychoanalysis in Times of Virtuality

Valeria Corbella

Abstract

The purpose of this chapter is to study the implementation of technology in today's psychoanalytical scenario. Many historical and cultural changes have taken place since Freud up to these days. To the contemporary subjective constitution, the human being is complex and determined by a myriad of biological, psychological, and social factors. Thus, culture is not external to the dimensions making up the subject, and technology plays a key role in people's current lives. Within the psychoanalytical technique, the setting has changed and adapted to the different social contexts, to the needs of each subject and also of the analyst. Contemporary psychoanalysis faces the challenge of setting up new scenarios to fit a new present that is taking shape. These are mixed settings, where the physical and virtual presences complement each other, simultaneously and alternately. Both the virtual and the physical realities are different and, therefore, do not replace each other. Thus, the purpose of this chapter is to reflect on the conditions that make possible the analytical encounter mediated by technology.

Keywords: psychoanalytic setting, psychoanalysis online, psychoanalytic technique, technology, acculturation, subjectivity, contemporary psychoanalysis

1. Introduction

This chapter aims to study how technology is implemented in today's psychoanalytical scenario. Many historical and cultural changes have taken place since Freud up to these days. To the contemporary subjective constitution, the human being is complex and determined by a myriad of biological, psychological, and social factors. Thus, culture is not external to the dimensions making up the subject, and technology plays a key role in people's current lives.

Within the psychoanalytical technique, the setting has changed and adapted to the different social contexts, to the needs of each subject and also of the analyst. From the beginning of the 20th Century, the use of the couch has been the most distinctive feature of psychoanalysis to differentiate it from other psychotherapies. By the middle of that century, written correspondence, the email, and the telephone also became part of the typical scenario. They were considered valid resources for patients who needed a closer contact to be able to be emotionally regulated.

The beginning of the 21st Century marks the advent of technology as part of the psychoanalytical setting, and with it, the movement known as e-psychoanalysis,

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which makes use of virtual platforms, including the use of the camera in online sessions and the use of electronic devices, such as the cell phone. These changes sparked heated debates, with voices in favor of and against the validity of online sessions.

Nowadays, there is mounting research supporting the validity and efficacy of the setting modified by technology. Many authors [1–11] assert the value of online psychoanalysis, claiming that the same processes can be found in in-person analyses. By means of vignettes or clinical cases, they make reference to the display of transference and countertransference and the presence of unconscious communication, free association and free-floating attention, emotional support, interpretations and the expression of defense, among so many other clinical phenomena.

On the other hand, the findings of neurosciences about unconscious communication, mirror neurons, and implicit memory help to strengthen the feasibility of online analysis. This way of communication takes place through various perceptual means, which can be visual, auditory, sensory, and interactive [10, 12, 13]. In other words, technology does not stand in the way of the development of the analytical process.

With the coexistence of in-person and virtual modalities, contemporary psychoanalysis faces the challenge of building new scenarios to adapt to a new present. These are mixed settings, where the physical and virtual presences complement each other, simultaneously and alternately.

The setting modified by technology has been studied mainly in analyses that resorted to the use of the phone or applications with video cameras, but other technological resources that are also part of the analytical field have been left aside. Thus, reference will be made to the use of WhatsApp and social media, which have not been deeply studied in connection to our discipline. In this sense, all the treatments are mediatized by virtuality, even when meeting in person. Therefore, further research into its uses, functions, and results is of the essence.

An essentially social practice, psychoanalysis is now facing a new present. The idea is not to set a limit to what is already known but to combine two logics that always go hand in hand: what is already known with what is about to be known. This ever-changing present demands new practices with tools that, although not novel, are being implemented on a large scale for the first time in the psychoanalytical community.

2. Tracing its roots

Going back in time, it is known that Freud started to outline the psychoanalytical technique based on his clinical practice treating patients with hysteria. He wrote his technical essays in which, although he did not give shape to a specific technique, he shared some tips. In them, transference is understood as a powerful work tool, which became the rule for the quintessential therapeutic dyad: Free association and floating attention. With these processes, it was possible to go around the repressive processes that hinder the approach to the deeper reasons behind mental suffering.

The couch underwent a similar evolution. At first, Freud used it due to his personal rather than scientific impossibility, since he found it difficult to hypnotize patients and to hold his patients' constant look. The couch became a trademark of psychoanalysis in that it prevented any censoring and moralizing mechanisms that could be expressed in the look.

At that time, he also raised the issue of the frequency and payment of sessions, as well as of the analyst's vacations and the behavior they should adopt. Thus, he set out a mode of work similar to an employment contract with guidelines for those

who were new to the profession. Those first steps, which were related to the technique, allowed Freud's followers to delve more deeply into the conditions that made it possible to work as an analyst.

Looking back, it is possible to see two key aspects of the Freudian technique which are still relevant today: The work with transference and the fundamental rule. A third element could be related to the good exercise of the technique, especially when it comes to the transference and countertransference phenomena: the analyst's analysis. Defined as the second fundamental rule, it is the analyst's ethical positioning that governs their good professional practice.

Freud did not mention the setting, but he did talk about possible paths related to the conditions needed to develop the analytical process, which have been the focus of analysis up to now. First made back in 1910, these suggestions have changed over time, and not all of them are currently implemented by analysts.

Many authors [14, 15] agree that the first ones to talk about the setting were Winnicott [16] and Bleger [17], who thought that it was the set of conditions that make it possible to psychoanalyze a patient. Both of them established their ideas within their own reference frameworks. Thus, the English author linked the notions of an enabling environment and holding needs with the emotional atmosphere of the analytical encounter. Following Winnicott, the holding was understood as an emotional support, which evokes the primary needs of the self necessary for a suitable emotional development, referring to the first mother-baby bond. Physical care is not related to holding but to handling. In this differentiation, Winnicott makes reference to the importance of an affectionate connection, which is maintained beyond the physical encounter, since analyst and patient build shared mental spaces that allow the other in. Thus, the analytical encounter is displayed in the transitional zone, a non-physical space for an exchange that is conditioned by the features of the play. It is a creative space between two subjects, which sits at the crossroads between the intrapsychic and the interpersonal dimensions.

Although from a different theoretical framework but supported on Kleinian ideas just as Winnicott, Bion [18] used the container-contained metaphor on which he underpinned the idea of reverie. The model also sheds light on aspects related to the baby-mother bond and the reciprocal influence of their mental processes. Just as Winnicott, and following the features of this primal bond, this author stresses the mental processes that take place in the analyst's mind when interacting with the patient's mind. Therefore, it could be said that also in this case the analytical setting sits within the analyst's mind.

Within the framework of the theory of symbiosis and influenced by River Plate psychoanalysis, José Bleger posited that the setting was a non-process that has stable variables which make it possible to differentiate the process from its circumstance. While Winnicott announces an intersubjective and relational model based on the bond with a good enough mother and an enabling environment, the Argentine author follows the guidelines towards the systematization of the analytical process. There is an independent variable that must be controlled (setting) so that what happens with the dependent variables (process) can be understood and interpreted. Some elements in the scenario remain stable; however, some aspects of the setting may become a process. Its rigidity may result in the deposit of psychotic or undiscriminated aspects of the personality: often silent, they crop up when the setting is modified [19].

There is a close link between the setting and the process or analytical situation. Without going deeply into the specific features of the latter term and the differences in how it is conceived and named, just as it was mentioned ([14], p. 491) "The analytical situation calls for a framework where to sit, which is the setting, wherein lie the rules that make it possible. These rules derive from the theories of

psychoanalysis and of the psychoanalyst, and arise from an agreement between the parties that make up the analytical contract". This is an important point: the setting, which makes the development of the analytical encounter possible, relies on the theories of psychoanalysis and on the analyst.

Psychoanalytical theories, as well as psychoanalysts, have undergone a change as this discipline evolved. This is due to the social and cultural influence of the different moments in time and the advances taking place thanks to scientific research. The beginnings of the 20th century are very different from today. Treatments and their settings have been modified by different reasons, among which can be mentioned the emergence of borderline and narcissistic pathologies, specific techniques to approach different clinical cases, research studies on the factors that play a role in the efficacy of treatments, among others.

What's more, the interdisciplinary work and the contributions of other sciences have helped to more deeply analyze the influence that social changes have on the subjective structuring. Nowadays, few are the approaches that do not consider the social aspect as part of their theories. Both social and humanistic sciences and the hardest factions of cognitive sciences, including neurosciences, posit the existence of a culture that recursively intervenes alongside the biological and psychological constitution of the mind [20, 21].

These transformations have been possible thanks to changes in the epistemological paradigms that make different disciplines scientifically consistent. In particular, psychoanalysis gave its first steps following a scientific method that merged with German idealism. This singular alliance of a scientific method and the ways to knowing, which persists until today, can be observed in the coexistence of systematic research studies that resort to the scientific method and those that implement methodologies stemming from hermeneutics and social sciences [22, 23].

With the inclusion of complexity as a new epistemological framework, the understanding paradigms begin to undergo yet another transformation. Binary logics, either in favor of or against methods, failed to account for the complexity that is typical of human beings. These epistemological innovations paved the way for cross-discipline research studies by which it was possible to approach the phenomena that were to be understood, and they did so in a more realistic way.

Thus, the subjective constitution of humans and their minds could no longer be excluded from the social and cultural context in which they live. The research methods typical of social sciences started to be valid –validity they had been denied in the past. These movements also relied on neuroscientific developments about the social brain. Gazzaniga [24] was the first to claim that the brain had a component he called "the interpreter." In other words, this scientist shed light on the fact that human beings know their reality by using different functions, depending on the situations they find themselves in. One of them is the interpretation of oneself and of others, as well as of behaviors, bonds, feelings, and the world around them. Hermeneutics and the art of interpreting are also ways to know and be in the world, and this does not seem to be just a theoretical presumption anymore, but part of human biology itself.

3. E-psychoanalysis

The beginning of the 21st century brought about important advances in technology. For instance, the Internet has certainly changed humans' lives. Globalization, post-modernity, and technology are the three pillars on which most of contemporary humans' lives take place. The lifestyle typical of the 20th Century seems prehistoric if compared with the hectic pace of post-modernity.

Technology is present not just in daily life but also in the subjective constitution. According to Tisseron ([25], p. 264), "digital tools [...] are causing a real anthropological revolution". The use of screens affects identity, the notion of time and space, some cognitive functions, and the concept of sociability, including transformations to the notions of what is public and private. More than a mere sociological reflection, these topics are part of the agenda of contemporary psychoanalysis.

The following sections will use a denomination often applied to the web. In a playful comparison, this naming is applied to Psychoanalysis, having moved together with these cultural and technological movements, from the inclusion of the phone and platforms with webcam to the incorporation of social media and their influence on the professional practice.

3.1 Psychoanalysis 1.0

This is the very first version of psychoanalysis. It dates from its start, back in 1900, when a couch, an analyst in floating attention, and a patient making free association would be enough for the transference phenomena to be displayed and help lift defenses, release the unconscious and dispel the symptoms.

The analytical situation was shaped by transference oscillations driving the unconscious processes. On the other hand, the in-person encounter was the rule. The distances did not pose any issues, except for questions about how to expand the frontiers of psychoanalysis. Distances were not easy to shorten, and mail correspondence as well as the phone communication proved to be possible alternatives –although not for many. Several analysts crossed the Atlantic Ocean both ways, seeking to be analyzed by the first experts in the field and then taking the method to other places. This is how psychoanalysis was transmitted, and in so doing it also adapted to the local cultures and possibilities. Anyway, the guidelines already mentioned were considered in the setting, and now the analyst's attitude should be added: neutrality and abstinence. The therapeutic bond typically entailed the doctor-patient model marked by the understanding, interpretation, and remission of the mental suffering.

After some decades, Heimann [26] and Racker [27] make use of countertransference as a key tool of the technique. This paved the way for the encounter with the patient as a field where forces coming from both participants of the therapeutic dyad interacted, and where unconscious fantasies sprang up [28].

At the same time, the psychoanalysis with intersubjective and relational approaches gained momentum, and the transference-countertransference couple took on new meanings in a stage where two minds met. So along the 20th century, the setting shows a movement from the external conditioning factors into the analyst's mind. Many of Freud's tips by 1910 would be considered secondary, depending on the clinical criterion applied by each analyst.

However, it has been Klein and Winnicott who gave shape to new specific features of the setting based on different theoretical models. Taking object relationships as a basis, Klein built a model to analyze children with a special technique. The scenario for the analytical encounter would serve as a stage for the introjection and projection of unconscious fantasies lying in the transference relationship. In this model, the doctor-patient link became a dyad, between the analyst and the analysand, in which elements of the relationships with the first objects, especially with the mother, would be represented.

The incorporation of pathologies of the self brings about changes to the theories and the setting. Winnicott discusses the need for a modified setting for patients with deficit self-structures. These modifications are not only about physical aspects of the office but also about the emotional availability on the analyst's part, which is related to the role of "a good enough mother." The setting is thus understood as

a space built by two, an intermediate space between the objective reality and the inner subjectivity. Winnicott's original contribution is the idea of the setting as a therapeutic element synonymous with reliability, affection and creativity.

The analytical encounter is seen from different angles depending on how the therapeutic stage is represented. In line with Farate [29], the models so far presented can be described by three metaphors: (a) the paternal metaphor, originating in the influence that the Freudian Oedipus complex has on the analytical setting, (b) the metaphor for the intrasubjective mother supported on the Kleinian model, which considers the notion of unconscious fantasies and object relationships, and (c) the intersubjective metaphor, proposed by Winnicott, wherein the analytical encounter is marked by a space sitting between two subjects.

Civitarese and Ferro [30], focusing on the contributions by Baranger, put forward a fourth metaphor: The analytical field. They posit that the analytical situation is a dynamic field, where unconscious bipersonal fantasies come up, which cannot be merely considered as the expression of instincts. Bion's ideas are implicitly present in this metaphor since the reciprocal actions of the mind of the mother and the child are the essential forces of that bond. This is possible by means of the communicative projective identification. It is a dynamism that will be projected in the analytical situation.

The contributions made by these authors occurred more or less at the same time, and are the first theoretical transformations to deeply influence the analytical setting. According to Lewis [31], it is the turning point from a "one-psychology-person" to a "two-psychology-person."

Represented by four metaphors, this historization gains relevance because the analytical situation and the setting are connected by the theories in the analyst's mind. The 20th century Psychoanalysis has been defined by major transformations, ranging from the understanding of the psychic apparatus to the subjective constitution of a person in relation to others.

Although the technical developments did not include technology at these first foundational moments, some indicial threads [32] anticipated what would happen with the virtual analytical settings.

Detailed below are the comments by some authors on this issue:

a. Martin ([33], p. 39) claims that "This patient wanted to be in touch with me. She had difficulty over what was aroused by the perceptual experience of the analytic hour but her feelings about me she could not express, so she made remote contact many times over the telephone".

b. Hannet ([34], p. 69) mentions that the phone served a specific role for patients who needed to appease their anxiety because they absent due to sickness; "the majority, however, registered their anxiety by telephone calls, asking the usual questions regarding what was wrong, what progress was I making, when would I be back, and so on".

There are previous references in the literature pointing to the use of the phone as a technical aid. This was authored by Saul [35], a pioneer in using technology within the analytical setting, although he suggests that other analysts at that time might have been implementing it –as is also mentioned in the references above. Upon a patient's request, this author systematized the use of phone sessions, in combination with in-person meetings, in order to lower the very high levels of anxiety caused by the physical encounter with the analyst. This is an impactful citation because it is quite ahead of its time and of the technology available back then: "In view of these considerations, one wonders if the idea of using modern technology in the form of the telephone, as an

adjunct to psychoanalytic technique, will be met with horrified resistance, or whether most analysts are already far ahead of this in their thinking and anticipate experimenting with televisual communication if and when this becomes practicable" (p. 287).

Saul foresaw the possibility to communicate visually through technology but it was necessary to wait for more than 50 years until platforms including webcams would make it true.

3.2 Psychoanalysis 2.0

The previous period slowly gave way to a more frequent use of telephone psychoanalysis, although it took longer to consolidate and become widespread among analysts. The most important drivers for this transition are to be found mainly when borders opened up, as did the migration of both patients and analysts. A social and cultural movement, globalization transformed lifestyles. The advance of technology and its large scale use made it easier to access mobile devices that help to shorten the communication distances. What was just for a few in the past has now become massive, reaching almost everyone.

Along with these cultural and technological movements, intersubjectivist and relational perspectives gained strength in different theoretical frameworks. According to Lewis [31] these approaches do not make up a specific school but they gave shape to perspectives that can be incorporated in all psychoanalytic streams. The main core moved towards the therapeutic bond, and the external factors, both spatial and temporary, which framed the setting of classical schools, were but secondary to the analytical encounter. The movement kept evolving very slowly, and by the end of the 20th Century and beginnings of the 21st Century several scientific articles about online psychoanalysis were published [36–41].

Within the telephone setting, several elements of the in-person setting were no longer present: the physical presence first, besides the visual and smell sensory perception. Bodies are muted yet not absent. Hearing is sensibly more acute and the voice penetrates into the ear in a slightly different way from the way it does in in-person meetings. As a patient said: "Your voice goes straight through my ear and reaches my mind. There is no air to soften the sound of your voice, I cannot stop listening, it has a direct impact and I cannot get you out of my mind." The transference resonance, even in virtuality, makes itself heard, consolidating an analytical encounter in which the dynamics of unconscious processes takes place.

In 2003 Skype was launched, and online communication platforms using webcams started to be incorporated into distance analyses. If the phone proved similar to the couch, since the patient did not see the analyst during the session, the webcam made it possible to work with patients that needed the analyst's look. The couch-face to face polarity became more flexible, and the absence of the couch did not mean that it was less psychoanalytic.

The tailormade analytical setting was a technical perspective that also adopted the use of technology in the office. The demand of patients who migrated and did not want to stop their analyses, long business trips, and temporary sickness or surgery leaves were the most frequent reasons given to analysts, whose resistance to the new modality started to recede, though not to the same extent in all cases. While research into online psychoanalysis moved forward, conflict arose over its validity.

By then, some analysts questioned the method, arguing that "it is difficult to accept the idea that psychoanalysis –or we psychoanalysts– have to go after society and the changing times. Our task is to understand and interpret the change" ([42], p. 15). Although criticism is understood and it is always wise to consider the latent meanings that could underlie a request for online analysis, thinking about psychoanalysis as detached from society and the changing times it goes through implies

untying it from culture. From the mid 20th century, psychoanalysis has emphatically underscored that the contribution of culture is one of the main components of the subjective constitution. If psychoanalysis is detached from its moment in history, the subject will necessarily be considered to be separated from its historical context –which is neither possible nor desirable. Although it is true that analyst and patient live in the same moment, distance psychoanalysis not always takes place within the same culture. This is an important aspect to take into account because when a virtual setting is used with foreign patients, the analyst takes special care to bear in mind the cultural differences between both. Cultural diversity does not hinder the process. Quite the opposite: it is often the driver of unconscious processes. This was implicitly said by a patient, who although belonging to a different culture, looked for an analyst of the same nationality as their late mother. Once again, it is possible to assert the feasibility of transference processes within the virtual setting.

The year 2009 proved key to the progress in scientific development since an International Psychoanalytical Conference was held, where several analysts [1, 12] posited the conditions in which the analytical encounter was possible when conducted virtually, showing, by means of clinical materials, the feasibility and efficacy of those treatments. From then on, different advances have made it possible to further understand the processes implied in the virtual mode [2–9]. A great deal of criticism [43–45] has been refuted with many clinical examples proving they were feasible [10]. Thus, notions such as neutrality and abstinence, holding, free association, transference, and unconscious communication took a life of their own online, by means of the clinical cases studied.

On the other hand, the virtual space was considered by many [46–49] to be a transitional space in a Winnicottian sense; "on this regard, the transitionality of the virtual space could provide a suitable path to encourage creative and collaborative processes between analyst and patient, in order to produce non-integrated affectionate states" [47].

Little by little, the virtual environment began to be more deeply understood. The analysis of similarities and differences with the in-person setting showed the specific features of each and also some warnings. It has been seen that the pathologies related to substance use, patients with suicidal ideation and psychopathies are not safely treated with this new modality. Further, the analysis of children through virtuality calls for further consideration and research since the child plays before the analyst, who may or may not intervene in this game.

Psychoanalysis 2.0 is still present nowadays and its use is expanding considerably. Between 2019 and 2020, due to the COVID-19 pandemic and the mandatory isolations in place in most countries, a large number of psychoanalysts have moved their offices online. To some, this was new news, although to many others this was already part of their routine practice. Yet although online practice is not novel –its first steps going back to 1951–, its large scale implementation certainly is. Detractors and defenders alike moved their practice online in order to continue the treatments needed by patients, but also in order to keep their source of work. A lot has been accomplished when it comes to understanding this new environment that combines physical and virtual spaces. But there is still a lot to be known. These times will probably prove to be fertile ground for debates on the new environment, which hopefully will give rise to multiple scientific productions to account for the results that analysts have obtained in their online practice.

3.3 Psychoanalysis 3.0

In 2006, anyone could open a Facebook account if they so wished. This gave rise to the advent of social media at a massive level. Twitter appeared in 2006,

and Instagram, WhatsApp, YouTube, LinkedIn, Snapchat, TikTok, among others, were launched in 2010, adding more features to meet users' communication needs. These communication platforms give rise to the web 3.0 and also to psychoanalysis 3.0.

Social media have drastically changed the way to communicate with others, and this is relevant to contemporary psychoanalysis. Analysts sometimes see that patients are constantly connected to their phones while on the session. Almost as a ritual, they look at the incoming messages, they apologize for reading them, for having to answer and then they comment on the content of the message. Others forward whole conversations to the analyst so they can read it before the session and then work on them. Are these the new ways for the free association? They show photos, videos, and they make us listen to songs they like. The first telephone contact with a potential patient has now mostly been replaced by a WhatsApp message. Many others, even if they have received recommendations, look for us on LinkedIn or google our names. If we pass the market test, they might send us a message. Others send us a friend request on Facebook, Instagram or they recommend visiting their Blog.

Countless situations may point at a setting that has been modified by social media, and to those who are not too familiar with them, these behaviors may seem invasive or indicative of resistance, to say the least. But are they? In line with the psychoanalytical view, it must be said that it depends on each patient, each situation, and each therapeutic bond. The fact itself does not determine the meaning; it should be further explored. Yet it is also true that, at least for the youngest and the not so young, social media are the communication environment in which they have built their subjectivity.

However, once again the bond between the setting and the way to conceive the analytical encounter becomes visible. What may be considered a resistance in some theoretical frameworks, in others it is an opportunity to research into new aspects of subjectivity [50].

Up to this point, light is shed on the intrapsychic and social field of the patient through the Internet. This aspect has been the most analyzed in research works, so there is more information available about it. But what about the analyst in the social media?

As far as I know, this new update of online psychoanalysis focuses on social aspects and modes of communication of the patient through the Internet. But much is yet to be understood when it comes to gaining insights into what happens with the analyst in social media. Despite the lack of a consistent understanding of the emotional and bonding effects of these new modes, the use of social media is an unavoidable fact that is present in the therapeutic relationship [11].

From the very beginning, the analytical setting was related to the analyst's neutrality and abstinence. Although these concepts have changed over time and due to new theoretical approaches, they are still present in contemporary analyses. One of the most compromising elements for analysts in the web is their anonymity. Macro data come from the corporate and consumption domains. Advertising is fed from them to pursue its commercial and service offer purposes. Demand is not explicit but it is conducted through online browse algorithms. Users expose their own data so that they can be used by the market [51].

It is very naïve to think that these terms are distant from psychoanalysis, since they are not: our discipline has also become part of the market. Psychoanalysis is also spread through the Internet. National and international psychoanalytical associations have websites showing activities, training courses, and the analysts that are members of the scientific community. Psychoanalysis is offered as a service within the Internet but also psychoanalysts as subjects are part of the web.

Patients and analysts share the same space, in which they upload aspects of their public and private lives, and which is not always protected by security policies. Classical terms such as anonymity, neutrality, and abstinence find barriers that come from today's lifestyle. One just needs to google a colleague's name to get at least some personal data.

The intimacy of the analyst is exposed in social media, which implies that anyone can peep into their social and family life. Births, trips, dinners, birthday parties, holidays, they are all part of the daily routine on Instagram, where *stories* are the stars. The security conditions related to the privacy of information are not to be trusted and may be overcome with some knowledge on technology –millennials know this. A careless use of technology within our discipline may lead the analyst to tread on dangerous ground.

What happens when a patient contacts us on Instagram? What emotional effects does the active participation of their analyst in social media, with the corresponding promotion of their activities and thoughts, have on the patient? Without a doubt, narcissistic aspects come into play but, at the same time, these are today's ways of communication. And once again, the same reflection: the fact itself does not make meaning but there might be unconscious signifiers behind them.

Just like Freud and his tips, some authors [52, 53] gave recommendations about how to safeguard one's profession in social media. Sfoggia and cols. [11] point out some research works about the behavior of therapists in social media, claiming that most of them do not accept friend requests from patients in treatment, although a lower percentage of those surveyed have an open profile in these platforms. These inconsistencies are fertile ground for future research with which to understand the effects these ways of communication may have. Although they are part of contemporary culture, the analyst must reflect on them.

Analysts have lost anonymity in other moments, and the same has happened to abstinence if it is understood in classical terms. These changes have given rise to more empathetical, less authoritarian, and why not, more humane manners in the analyst. The rigidity present in the past gave way to a more elastic technique and a more flexible analytical setting according to the needs of each patient and the possibilities of each analyst. However, this calls for a responsible assessment of the new elements arising in the setting and from technology. They should also be analyzed taking into account the conditions that help or hinder the analytical encounter.

4. Conclusions

The intention to name psychoanalysis by web updates is a metaphor for how technology advances into our professional practice. The manifold penetration of virtuality in humankind is an object of study typical of the complex times we are living through. The paradigms that made it possible to understand the culture and society of the 20th Century are not enough if one intends to grasp these postmodern times. Globalization and technology have come together to dress the professional practices in new clothes. The time and space categories have also been updated, and are no longer hindering the work practice. And it is this scenario that gives rise to e-psychoanalysis. The analytical field and setting have been modified not only for practical reasons but also in a deeper sense. The stage is constructed and deconstructed in the minds of its participants and no longer relies exclusively on specific and physical movements.

The historical transformations in the analytical setting have anticipated the possibility of a virtual setting. In my view, the main condition originated in those authors whose original contribution was to move the analytical setting into the

analyst's mind. They could get rid of the material borders and paved the way for what many have called the analyst's inner setting. Sitting inside the analyst's subjectivity, it gathers those internal theories that are deployed with their personality traits. As it was mentioned before: the setting depends on the theories and on the analysts themselves, while the social and cultural context set the pace. Virtuality is not only present in technology, but the mind is understood as an immaterial space.

This year has presented a new context that announces a cultural scenario mediated by technology. It has been possible to see the relentless nature of many of these changes, most of which are likely to linger on in the near future. The online setting will be able to coexist with in-person sessions, not without some tension. These will be cases of what is known as blended-psychoanalysis –a hybrid that meets the needs of contemporary men and women. It is a new language that takes into account the specific nature of psychoanalysis. The analytical encounter is a field of interaction between two subjects where movements of unconscious processes converge. In this sense, technology neither enables nor hinders the field –rather, it is just the medium that facilitates the encounter.

Anyway, one should not be naïve, and several disciplines are paying attention to its reach and, especially, to the consequences this technology advance can have. Posthumanism and transhumanism posit models in which the humanity of the subject becomes blurred as it is absorbed by technology. Online psychoanalysis is far from these positionings but it cannot overlook the risks entailed. The analyst is responsible for putting forward the tension between two overlapping logics: what is already known with what is about to be known about the conditions for the possibility of the subjective constitution in a world that moves at a dazzling pace.

Author details

Valeria Corbella
Catholic University of Argentina, Psychoanalytic Association of Argentina, City of Buenos Aires, Argentina

*Address all correspondence to: mariacorbella@uca.edu.ar; valeriacorbella@yahoo.com.ar

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Section 4

Interesting Approaches in Dialogue

Chapter 7

Culture Free CBT for Diverse Groups

Peter Phiri, Isabel Clarke, Lydia Baxter, Kathryn Elliot, Shanaya Rathod and Farooq Naeem

Abstract

Traumatic experiences are known to have a significant impact upon one's physical and mental health. Post-traumatic stress disorder (PTSD) is understood to be a common mental health consequence of trauma. However, Complex Trauma and consequences of adverse childhood experiences appear more prevalent and a serious public health concern that hinders the individual's daily existence, thus emphasising the need to implement a culturally free treatment intervention. In this chapter, we begin by introducing traumatic experiences in several contexts and explore the treatment for trauma. It will focus on a research study that employs Comprehend, Cope and Connect (CCC), a third wave CBT approach, to deliver a culturally free form of therapy that has been adapted for individuals from diverse populations. The CCC approach's relevance to cultural adaptation is explained and discussed through the use of two case examples from the main study. The Culture Free study found that CCC was both feasible and acceptable in diverse populations, echoing existing research on cultural adaptations which found use of mindfulness to be accepted and appreciated as an effective intervention that can elicit concrete positive change across a broad range of mental health presentations, including trauma and trans-diagnostically. Further investigations utilising a robust methodology and powered sample are warranted in particular with diverse populations presenting with complex trauma.

Keywords: comprehend, cope, connect, CBT, trauma, ethnicity, culture

1. Introduction

This chapter explores the treatment of trauma taken in a research study employing the Comprehend, Cope and Connect (CCC), third wave CBT approach, in delivering therapy to people from diverse ethnicities within a primary and secondary care service setting. CCC and its relevance to the treatment of diverse ethnicities will be explained; the CCC approach to trauma will be elucidated, and illustrated by discussing two case examples in detail from the main study.

Trans-diagnostic approaches have been gaining favour recently [1, 2]. Promising outcomes have been found in trials of therapy that is trans-diagnostic across anxiety disorders [3, 4]. The need for more expertise in treatment of trauma within psychotherapy services such as recognised by Murray [5] 's programme to teach trauma focused CBT to 20 therapists from 10 IAPT services resulting in improvement in client outcomes on a PTSD measure following the training.

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Because the approach used is trans-diagnostic, and formulates linking current crisis with past adversity, a broader definition of trauma is used. The study offers the opportunity to review aspects of trauma and past adversity as these impinge on current mental health challenges in a broad community sample, not selected specifically for trauma. This data allows a sense of the continuum of impact of the past on the present within an ethnically diverse, general mental health, sample to be gained.

1.1 Trauma in context

Complex trauma refers to repeated and cumulative trauma that usually occurs over a period of time and within a specific context. The term was developed in the past decade by researchers who discovered that certain forms of trauma were more complicated than others [6, 7]. Many forms of trauma fall into the category of complex trauma including, domestic violence and attachment trauma, due to these forms of abuse occurring over a significantly extended period of time. The understanding extends to other types of traumatization occurring in childhood and/or adulthood for example, armed conflict and war, displacement, refugee status and forced relocation. Trauma may also result from chronic and ongoing health conditions due to a single event such as being witness to a sudden traumatic death of another. While the concept of complex trauma has been accepted, neither the DSM nor the ICD has included it; however, the upcoming ICD 11 is going to include the diagnosis of complex PTSD to describe complex trauma.

There is a vast body of research that demonstrates the strong association between adverse childhood experiences and trauma and the development of negative health and social outcomes later on in life [8]. Compelling research on the Adverse Childhood Experiences (ACEs) has aided in comprehending these links [9]. ACEs refer to any traumatic or commonly occurring stressful event, such as various forms of abuse, neglect and witnessing violence, which occurred before the age of 18 years old. Several large scale population based studies confirm the causal relationship of ACEs with poor emotional and physical outcomes. Bellis [10, 11] studies reported 50% of children within the UK experience at least one ACE, with four or more ACEs experienced by 12% of the UK population. Those individuals who experience a greater number of ACEs are at a higher risk of negative socio-economic issues such as, lack of education and job opportunities, increased risk of experiencing intimate partner violence, low emotional wellbeing and life satisfaction. Furthermore, if a person experiences one form of abuse, there is an 87% increase they will endure other forms of abuse. This equates to the more abuse one experiences the higher their risk of negative health and psychosocial outcomes in years to come [9].

The various mental health outcomes for which ACEs are risk factors is very broad. Those that occur during childhood, include attention-deficit hyperactivity disorder and oppositional defiant disorder; and during adulthood include, depression, anxiety disorders and personality disorder as examples [12]. Individuals who have been subjected to childhood trauma of physical or sexual abuse are more prone to get an admission to a psychiatric hospital; increase of self-harm and suicidal behaviour, and an overall higher global symptom severity [13]. Kessler et al. [14] provided conclusive evidence from 21 countries, which stated childhood adversities associated with maladaptive family functioning (e.g., child abuse and parental mental illness) were the strongest predictors for mental health disorders. The implications of the research findings are significant in depicting the causal relationship of childhood adversity and mental health disorders in order to facilitate the development of appropriate treatment plans.

1.2 Racial bullying

Following on from the adverse childhood experiences mentioned above, there is an increasing number of publications examining the prevalence of bullying – a repeated aggressive verbal, physical, or psychological behaviour – among children and adolescents, and the psychological consequences of bullying. Research has found that those exposed to bullying as a student, whilst at school, has shown a strong association with a negative impact on mental and physical health later on in life [15]. Specific focus has been given for bullying based on stigmatised identity, for example their race. Racial bullying has many similarities in terms of characteristics with discrimination as the maltreatment of the individual is due to their membership of a socially disadvantaged group. An investigation found that within the youth population, racial bullying had significant associations with poor mental health and increase in substance use compared with non-stigma based bullying [16]. Rosenthal et al. [17] concluded similar findings, with greater experiences of racial bullying indirectly associated with multiple adverse health outcomes including an overall decrease in self-assessed health across the span of 2 years. Furthermore, emerging evidence suggests that bullying may be associated with the development of psychosis. Schreier et al. [18] investigated whether there was an association between peer victimisation and psychotic symptomatology in a cohort of adolescents aged 12 years and concluded that peer victimisation was associated with psychotic symptomatology in early childhood.

1.3 Repeated violent relationships

As mentioned, intimate partner violence (IPV) is traumatising and remains a serious public health concern that affects 30% of every partnered women globally. The most prevalent mental health outcome of IPV is PTSD, ranging from 31% to 84.4% among IPV survivors, second is depression with a weighted mean prevalence estimate of 48% [19]. An association has been reported by studies between previous IPV and subsequent violence highlighting the role of PTSD in increasing the risk of future psychological abuse. Krause et al. [20] longitudinal study of IPV survivors found PTSD symptoms significantly associated in the increased likelihood of IPV after 1-year follow-up. Additionally, Bell et al. [21] concluded similar results that the more severe PTSD symptoms in women increased the risk for psychological abuse at an 18-month follow-up. Finally, data from the Chicago Women's Health Study reported the severity of PTSD symptoms is a predictor for future IPV [22]. Therefore, three of the four published studies revealed PTSD symptoms to be a predictive factor for future IPV. Albeit that the prevalence of PTSD and depression are evident mental health risk factors for future interpersonal violence, yet there is limited research that determines the impact specific interventions have upon reducing and preventing mental health outcomes that pose as a risk for future IPV among this vulnerable population.

1.4 Psychological impact of migration

Migration is a process whereby an individual leaves one geographical area for a prolonged or permanent move to another geographical area, due to reasons of economic gain, political upheaval, conflict or other reasoning. Over the last decade, migration has grown at an international level with an estimated 3.1% of the world population having internationally migrated. Migration is a complex process that differs for each individual, yet most often individuals experience stressful events such as violence, war, and persecution. There is often no adequate preparation

nor social support given, difficulties present in the form of barriers, leading to psychological distress and resulting in a negative impact on psychological well-being. There are several studies that globally depict the impact on migrant population's mental health, for instance, its impact on incidence of psychosis in African Caribbeans in the UK and Caribeean Islands [23, 24]. Another study by Bhugra [25] conducted in Trinidad and Barbados and on UK African Caribbean population confirmed the impact of migration on the UK migrants in comparison with those in the country of origin. This was further endorsed by Canter-Graae's and Selten [26] meta-analysis which established the significant risk of developing schizophrenia in the migrant populations. In a classic study [27], reported hospital admission rates for schizophrenia were higher among Norwegians who had migrated to the United States compared with Norwegians who stayed in Norway. The result of this increase was based on the migration process these individuals endured. This study is now the benchmark and set the standard for additional studies on comparing the rate of schizophrenia and other psychiatric illnesses in those who migrated to those who did not migrate. Research concludes the exceptional vulnerability migrants have for developing mental health disorder, and yet the local and international efforts to respond are unable to meet the demand. Psychological interventions need to consider the role of migration distress in assessment and formulation stages. It is paramount to understand why individuals might decide to migrate, elicit pre-migratory stressors and the risk factors associated with this phenomenon. There is an imperative need to develop culturally-sensitive services with trained professionals to implement appropriate interventions that aid in preventing psychological distress and promoting positive mental health and well-being among migrants.

1.5 Cognitive behaviour therapy

Cognitive Behaviour Therapy (CBT) stems from principles of cognitive theory [28] and implements both learning and conditioning in order to treat mental health disorders. Various techniques can be used including cognitive restructuring, exposure and the application of copying skills. CBT is typically delivered in 8 to 12 weekly sessions [29]. The general aim of cognitive therapy is to help individuals identify their unhelpful thoughts and modify beliefs in a way that encourages them to cope and ultimately change negative behaviours [30]. There is an abundance of research that supports the efficacy of cognitive therapy for treating trauma in adults. In addition, there is evidence to support using CBT to treat depression, anxiety, and symptoms of post-traumatic stress disorder (PTSD) resulting from sexual assault, industrial accidents and natural disasters [31].

CBT programs are typically implemented once a week over the course of a number of weeks, however, where this may be a barrier in regards to patient commitment to treatment over long periods of times, and interference with social functioning, researchers have argued for a more intensive delivery of CBT that has been proven to be just as effective as the standard delivery of cognitive therapy [32].

CBT has been consistently proven to be a better treatment of PTSD than relaxation training control groups. Furthermore, it has been shown that CBT is well maintained in follow-ups [33]. Despite the evidence suggesting the efficacy of CBT, many researchers still argue that the results obtained from randomised controlled trials are unlikely to be replicated in clinical settings. Reasons for this could include; inadequate staff training and experience, heavier caseloads, and more comorbidity among patients [33].

Research has found that psychological interventions can significantly reduce PTSD symptoms in adult survivors of childhood trauma. Previous meta-analyses emphasises that trauma-focused CBT (TF-CBT) is the most effective for PTSD. In

addition, researchers suggest that TF-CBT should be used as a first-line treatment for PTSD [34]. It has been argued that trauma-focused treatments show significantly larger effects compared to non-trauma interventions such as managing anxiety, problem solving and supportive interventions. A limitation of this research is that adult PTSD survivors from childhood abuse are significantly underrepresented in existing research. Some authors have argued that trauma-focused treatments are not appropriate for individuals with PTSD due to emotion regulation difficulties caused by childhood abuse and that participants would have to re-live traumatic events [34].

Much previous research regarding PTSD has focussed primarily on male veterans. Recent research has tested the efficacy of CBT with a female population. The results found that prolonged exposure (a type of CBT) resulted in a greater reduction of symptoms compared to women who received a supportive intervention [35]. Thus, highlighting that CBT can be effectively generalised to the female population.

In addition to using CBT to treat trauma in adults, research also shows that CBT is an effective treatment for PTSD in children. However, children suffering from trauma have limited access to evidence-based interventions. This is a huge issue as research proves that access to empirically supported PTSD treatment can be vital in treating the effects of trauma exposure [36].

2. Comprehend, cope and connect (CCC)

2.1 Rationale for culturally sensitive psychological interventions

The Western cultural bias of commonly available psychological therapies, including CBT has been identified as a barrier to both engagement and effective treatment of people from diverse ethnicities, and the development of culturally adapted and culturally sensitive forms of therapy is a response to this issue [37–46].

The current study seeks to address some challenges that have emerged during the course of this endeavour. Specifically, where adaptation relies on aligning to a particular culture, this limits applicability in a situation, such as that found in urban areas of the UK, where people from multiple ethnic groups co-exist. Further, mental health challenges are more likely to be viewed in spiritual and religious terms by non-Western societies and therapies such as conventional CBT tend to favour a diagnostic conceptualisation that can feel alienating to these cultures if not culturally responsive.

Third wave CBT approaches are built around the use of mindfulness in order to create distance from patterns of thought and behaviour leading to malfunction. These therapies are normally applied trans-diagnostically, and because of the spiritual origins of mindfulness, sit more easily with the non-Western mind-set. CCC, founded as it is in basic cognitive science, discards much of the complexity of other approaches and works with the universal human need to establish a tolerable internal state. Where this state is hard to reach, malfunctions that get labelled as ‘symptoms’ within the illness paradigm result, and can become established. The role of trauma in complicating the achievement of a good enough internal state, or sense of self, is given pride of place within the CCC formulation, and CCC has a distinctive approach to trauma which will be explored below.

2.2 The intervention

CCC was first evaluated within Acute Mental Health services [47–50], and developed for delivery in a primary care, Increasing Access to Psychological Therapies (IAPT) service, for complex cases [51]. Within primary care, the programme consisted of four individual, collaboratively arrived at, emotion and trauma-focused

formulation sessions, followed by a 12 week group, skills based, intervention, targeting emotion management and behaviour change. One or two review sessions concluded the programme. The manual for this primary care programme [51] was adapted for the CCC Culture Free manual by the authors IC, LB, PP & FN.

2.3 The manual

The adaptation welcomed inclusion of family members, carers, into the therapy, added somatic elements, made more space for spirituality and religion and added teaching stories.

The Culture Free therapy was briefer than the primary care version because it was targeted more widely. Within the IAPT service, the approach was reserved for complex presentations predicted or proved to be unresponsive to routine protocols. However, the participant group for the current study also included a high proportion of people with complex trauma and relationship issues. It was further hypothesised that involvement of the wider system might assist skills utilisation in the natural environment, so allowing for a briefer therapy, as noted in earlier studies (Naeem, personal communication).

The first four sessions covered open-minded listening to the individual's story and collaboratively drawing this together into an emotion-focused diagrammatic formulation. This incorporated the effect of trauma on current presentation and explained it to the client as covered in Section 3.2 below. Maintaining cycles are identified, along with skills needed to break them. Breaking these cycles informs the choice of goals. This formulation is also summed up in a compassionate letter discussed with and sent to the client. The subsequent four to eight sessions cover skills and behaviour change needed to break the vicious cycles.

2.4 Modifications to the manual

Refining the manual was a major aim of the study and the manual was revised in the light of new learning arising from the particular challenges that emerged during therapy delivery. Model adherent procedures to meet them were discussed in clinical supervision (with investigators IC, LB & PP), implemented and evaluated accordingly. Successful solutions were added to the manual, below.

Specific modifications included:

- How to proceed, without psycho-education in the Western viewpoint, where the individual sees their issues in somatic rather than psychological terms.
- Cultural difference in attitudes to assertiveness and anger.
- Managing family expectations where these appear detrimental to mental health.
- Discussing sensitive issues such as sexual abuse in the context of religious and cultural complication.
- Framing psychosis in a religiously and culturally, non-stigmatising way.

The pilot aimed to explore the feasibility, acceptability and effectiveness of CCC a novel third wave CBT integrative approach as a trans-cultural therapy intervention. The objectives included reduction in symptoms of emotional health problems and disability.

2.5 Participants

A total of (n = 32) participants with mental health problems were recruited into the study from Improved Access to Psychological (IAPT) Services and secondary adult mental health services, in a Hampshire NHS Foundation Trust.

Outcome measures were administered at baseline, end of therapy and at eight week follow-up period.

These included:

- Clinical Outcomes in Routine Evaluation (CORE) [52]
- The Hospital Anxiety and Depression Scale (HADS) [53]
- The Bradford Somatic Inventory (BSI) [54]
- WHO Disability Assessment Schedule v2.0 (WHODAS) [55]
- Patient Experience Questionnaire (IAPT- PEQ) [56]

The final results of this pilot have been prepared for submission. Repeated measures analysis of variance (ANOVAs) for outcome variables: HADS –depression scores indicated a significant effect when all three time points were compared simultaneously; F (2,36) = 12.81, $p < .001$, partial $\eta^2 = .42$. Bonferroni adjusted pairwise comparisons indicated significant reductions from baseline vs. post-treatment 11.21 (SD =4.28) to 7.11 (SD = 3.99) on the HDAS –depression $p < .004$ and baseline vs. follow-up 7.21 (SD = 4.99), $p < .001$. However, there was no significant difference between post-treatment and follow-up, $p < 1.0$.

HADS –anxiety scores was significantly different when all three time-points were compared simultaneously, F(2,26) = 9.93, $p < .001$, partial $\eta^2 = .36$. Bonferroni adjusted pairwise comparisons indicated significant reductions from baseline vs. post-treatment 14.53 (SD =4.01) to 11.05 (SD = 3.40) on the HDAS –anxiety $p < .003$ and baseline vs. follow-up 11.21 (SD = 4.05), $p < .001$. However, there was no significant difference between post-treatment and follow-up, $p < .831$.

WHODAS was significantly different when all three time points where compared simultaneously, F(1.29, 14.18) = 6.73, $p < .001$, partial $\eta^2 = .38$. Bonferroni adjusted pairwise comparisons significantly reduced from baseline to post-treatment 66.58(SD = 40.13) to 44.42(SD = 44.42 (SD = 32.35), $p < .034$ and baseline to follow-up 38.75(SD = 26.499), $p < .014$.

CORE Total score was significantly different at three time points, F(1.25, 18.72) = 14.98, $p < .001$, partial $\eta^2 = .5$. Bonferroni adjusted pairwise comparisons indicated significant reductions from baseline to post –treatment 76.81 (SD = 23.26) to 49.25 (SD =27.00), $p < .002$, and baseline to follow-up, 52.19 (SD = 25.72), $p < .001$.

3. Trauma in CCC

This section will take a more CCC adherent definition of trauma. The therapy is founded on felt sense; how the individual manages their subjectively experienced internal state. This is impacted by trauma in the present because of the way the threat system operates across time. What is significant here is the individual perception and experience of threat. Frequently, this originates in an identifiable trauma, such as child abuse, rape, violent relationship etc. However, it is not always possible to pinpoint its origin so precisely. Memory is impacted by such circumstances. Family and other interpersonal dynamics that would not be identified objectively as

constituting trauma can be experienced at a level of acute threat, particularly allied to individual sensitivity. CCC judges trauma by current presentation; disproportionate response to events in the current environment evidences triggering of earlier experience that has sometimes become hazy or lost to consciousness. Validating the likelihood of this explanation is the first step to someone being able to take responsibility for distancing themselves from threat driven reactivity.

A total number of (n = 32) participants were recruited into the Culture Free study as per study protocol. However, the majority of the participants had suffered earlier adversity that impacted on their current functioning as identified within the formulation, and many of these fell within or near the category of Complex Trauma, that is included in the (draft) ICD 11 (but not DSM V). ICD-11 CPTSD includes the three PTSD clusters and three additional clusters that reflect 'disturbances in self-organization' (DSO): (1) affective dysregulation (AD), (2) negative self-concept (NSC), and (3) disturbances in relationships (DR). These disturbances are proposed to be typically associated with sustained, repeated, or multiple forms of traumatic exposure, including childhood sexual abuse and severe domestic violence, represented in some of this sample, reflecting loss of emotional, psychological, and social resources under conditions of prolonged adversity [57]. It is the effects as opposed to the originating circumstances that are treated in the current study.

3.1 How Trauma activates the body's threat system across time

An important element of CCC is communication and motivation, so that a way of presenting the interference of past trauma in current functioning that is both true to the facts, easily graspable and translates into practical management is key. There are two fundamental processes that need to be understood and communicated relevant to response to trauma. One is the autonomic arousal response, mediated by the parasympathetic nervous and poly vagal systems. The other is the singular nature of trauma memory.

To start with memory, dual processing models of human cognition provide a straightforward way of understanding the phenomenon of involuntary and immediate trauma recall. Brewin [58] reviews studies of animal conditioning and concludes: 'This evidence points to an important distinction between hippocampally-dependent and non-hippocampally-dependent forms of memory that are differentially affected by extreme stress.' This leads to the identification of separate memory systems underlying vivid re-experiencing versus ordinary autobiographical memories of trauma. Brewin [58] refer to these as verbally accessible memory (VAMS) and situationally accessible memory (SAMS). The differential effect of stress elucidates the facilitation of access to SAMS through high arousal states in the present. Ehlers & Clark [59, 60] incorporate the same sort of distinction into their widely adopted model of PTSD, using Roediger's [61] distinction between conceptual and data-driven memory processing, to explain this phenomenon of re-experience of past events.

Since that time, there has been extensive investigation of the nature and precursors of such intrusive memories, often using analogue studies of individuals shown traumatic film under various conditions. The wider role of hormones, including stress hormones and more precise information about the areas of the brain involved through use of fMRI images have been studied [62].

As well as featuring in time violating, intrusive memory, trauma disrupts the autonomic nervous system, leading to sensitization to perceived threat, and heightened vulnerability. This is aversive, and so in turn leads to avoidance, both of an ever generalising pool of triggers and reminders, and of close relationship, which disrupts the very sources of support people normally rely on. Early and repeated trauma, leading to overactive cortisol production, leads to lasting disruption to these systems [63].

As well as the heightened atunement to threat this represents, dissociation; involuntary mental absence; is another result of trauma. Physically this can be traced to the poly vagal response to extreme trauma; the freeze response. This has the additional effect of shutting off the affiliative arm of the poly vagal system [64].

3.2 The CCC explanation

The Interacting Cognitive Subsystems (ICS) model of cognitive architecture [65] distils this information into a useful map of connections and disconnections within the brain. ICS posits two central meaning making systems, the implicational and the propositional, each with their own memory system, representing the evolutionarily older and newer parts of the brain respectively. Normally these communicate, but can become desynchronized at high and low arousal. This leaves the older, emotional and threat attuned, implicational subsystem, in charge without access to the contextual information from the propositional. This model provides a succinct rationale for the background to trauma symptoms outlined above that is communicated within CCC by means of a modified form of the Dialectical Behaviour Therapy States of Mind diagram (**Figure 1** below) that adds the separate memory systems.

This states of mind diagram with addition of memory provides a normalising explanation. For many people, this lifts the stigma of a sense of innate pathology and substitutes a simple rationale for the unbearableness of current adversity which for other people would be more manageable.

It also ushers in the agenda of facing up to the past trauma and its potential to intrude into the present if not managed. Mindfulness provides a means to do this without being overwhelmed by the accompanying emotion, and, importantly, to disentangle what belongs to the past from what belongs to the present. Much of the therapy is focused on identifying strengths and potential and finding new, effective ways forward. There is growing clinical evidence, which needs back up by proper research study that this can enable people to move forward from even serious trauma without need for detailed reliving.

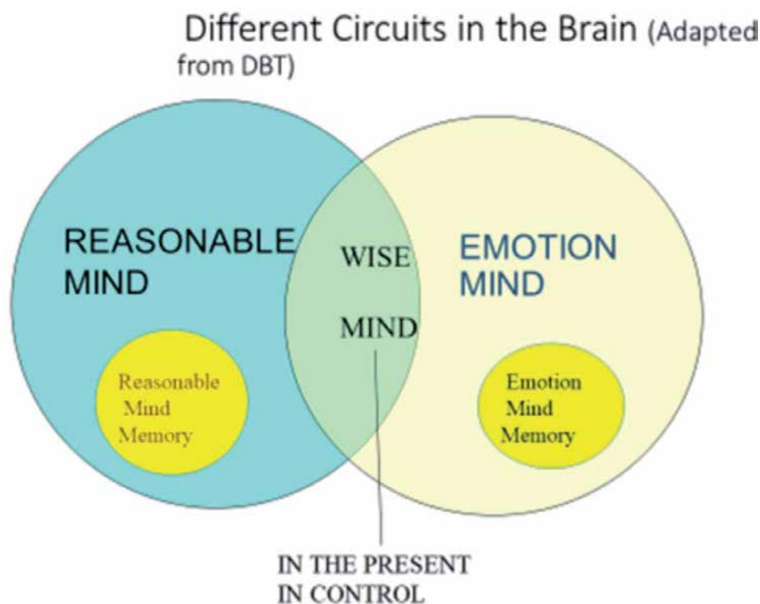

Figure 1.
States of the mind. From Clarke, I. (2016). Reproduced with permission from Hodder & Stoughton ltd.

Another feature of CCC is that it is trans-diagnostic – or perhaps more accurately, blind to diagnosis. Most of the literature on therapy for trauma starts with a diagnosis of PTSD, and this certainly makes research tidier. CCC has developed particularly in situations where diagnostic uncertainty abounds, such as Acute and Inpatient Mental Health Services [48] and those who fail to benefit from diagnostically organised protocols in primary care. Unsurprisingly, trauma of one sort or another, usually of the complex variety, features heavily in both these groups, and only a minority will have a diagnosis of PTSD.

3.2.1 Participants' experience of trauma

Table 1 above lists the IAPT study participants (n = 20) and elements, if any, of complex trauma as identified in their formulations, along with the disproportionate current response attributable to the impact of the past. This table illustrates the universality of some sort of trauma or earlier adversity impacting present functioning within a community sample selected for ethnic diversity. Some of the instances are culturally connected (e.g. illegal immigration status and racial bullying), but many would be found in any sample. This illustrates the ubiquity of the impact of such past adversity on mental health presentation. The table also lists the interventions applied in addition to mindfulness. See Appendix 2 for the principle interventions post formulation.

3.3 Case Example 1: 'Celine'

3.3.1 Background and contact with the service

Celine was a 58 years old woman of mixed race heritage, born in French Guyana. She moved to England with her family in her teens. She was a mother to three children, two older ones from a first marriage and a 10 year old daughter from her second marriage, at the time of therapy. Celine and her parents retained strong family connections with country of origin, Guyana. Relations with the wider family were important to her, but could also be a source of stress where she was expected to fulfil a particular role by powerful individuals.

She was recruited into the study and received 8 sessions of Culture Free CCC. Previous psychological history revealed several previous episodes with mental health services; two episodes for support with her employment difficulties, and one further episode when she first received generic group input, and was then stepped up for individual therapy and received 15 sessions of CBT for Generalised Anxiety Disorder (GAD), without achieving reliable improvement.

She was a well-educated high achiever and had made a good career as a Solicitor specialising in business and financial cases. A critical incident for her was in 2008 when she had loss in her daughter at about the same time as she lost a parent. She struggled to cope; she related that her second husband and the firm she worked for were unsupportive. Her psychiatric history revealed a diagnosis of depression in 2008 and she had been on anti-depressants from then on.

She reported that the attitude of her employer to her health struggles developed into bullying and discrimination with strong racial overtones. She reported feeling she did not fit into the firm and desperately wanted to leave the job and change career. She described her marital relationship had become increasingly abusive and controlling.

3.3.2 Initial therapy session

At the point at which Celine entered therapy, she had managed to separate from her husband, to leave her job and embark on a training for a new career in the social care

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Case No	Earlier life experiences (Traumatic context)	Presenting problem and impact of past.	Specific CCC Coping Strategies in addition to Mindfulness.
1	Childhood abuse (by a close family member), age 4 years, and neglect; judgmental mother - unrealistic academic expectations.	Acquiring physical disability (fibromyalgia and chronic pain), triggers sadness, anger, shame and anxiety, and feeling useless	Building a new relationship with the past: Self compassion
2	Childhood abuse. Domestic violence from partners.	Anger and cannot cope when feeling unsupported, let down in the present. Unassertiveness.	Building a new relationship with the past: Self compassion; Positive Anger Work
3	Over-looked academically as a girl; sense of injustice. Sexual abuse by older brother told not to tell (approx. 7 years old) told mother, who blamed and chastised her for the act.	Unacknowledged in current family leading to disproportionate depression and anger	✦Emotion Management; Self compassion
4	Punishing and neglectful mother. Anxious childhood.	Inability to deal with emotions. Avoidant of relationships	Self-compassion; ✦Emotion Management
5	Childhood trauma. Father nearly died in car crash when 9 years old. Family pre-occupied with impact on sibling.	Obsessional thoughts regarding harm to daughter. Avoidance.	◆Arousal Management; *Aspects of Self; Self compassion
6	Extreme childhood fear engendered by tales of black magic.	Post-natal fears for safety of son. High anxiety. Compensates with controlling pre-emptive and perfectionist behaviours.	Arousal Management; Building a new relationship with the past; ✦Emotion Management
7	Neglectful and chaotic childhood. Alcoholic father	Avoidance of emotion leading to constant activity and chronic stress. Alcohol.	◆Arousal Management; ✦Emotion Management
8	Multiple deaths of family members coming close together	Obsessive health anxiety	◆Arousal Management; Self compassion; **Relationship management
9	Shamed within family as teen for (culturally unacceptable) homosexuality. Physical and emotional abuse by mother. Father left when 3 years old.	Envy, anger, relationship and career difficulties. Loneliness Copes with perfectionist ideas but behavioural inactivity (fear of failure)	◆Emotion Management; **Relationship management
10	Sister preferred. Rape by ex-partner. Racism at work.	Low self-esteem. Perfectionism leading to high stress.	Positive Anger Work; Aspects of Self; Relationship management
11	Childhood trauma - Mother left. Sex abuse by a parent at 12 years. Abusive childhood. Adult trauma – Loss of daughter in a road traffic accident (RTA). Impact of RTA -reduced memory, increased emotionality and impulse control.	Flashbacks. Dissociation. Low self-esteem. Problems with emotions and relationships	Building a new relationship with the past; ✦Emotion Management; **Relationship management

Case No	Earlier life experiences (Traumatic context)	Presenting problem and impact of past.	Specific CCC Coping Strategies in addition to Mindfulness.
12	Childhood trauma – loving family, experienced war conflict while in Turkey during Kurdish and Turkish conflict – witnessed village members being tortured by soldiers. 'Reported seeing 'Jinns', dead bodies and evil spirits' – hallucinations? Adult trauma - Illegal immigrant for 14 years – experienced extreme anxiety and feeling under attack from others.	Panic, hypervigilance, avoidance of crowds and exercise.	♦Arousal Management; +Emotion Management
13	Mental, physical and sexual abuse.	Avoidance of emotion. Avoidance of intimacy.	Building a new relationship with the past; **Relationship management; +Emotion Management; *Aspects of Self
14	Childhood sexual abuse by a parent between 5 to 12 years. Experienced 13 years of mental and physical abuse from husband.	Emotionally overwhelmed. Withdrawal and unmotivated, or dysregulated anger.	♦Arousal Management; Relationship management; Self compassion
15	Emotionally abusing and criticising childhood.	Dissociation. Emotional overwhelm and relationship difficulties.	Positive Anger Work; +Emotion Management; Self compassion
16	Migration age 19 years of age; hostile in-laws. Major health difficulties severely impact marriage.	Suicidal and self-harm. Low mood.	♦Arousal Management; **Relationship management; Self compassion
17	Unhappy childhood; Migration distress. Breast cancer.	Obsessive anger at neighbours leading to conflict	♦Arousal Management Positive Anger Work; +Emotion Management
18	Diagnosed with Autism. Early childhood developmental problems.	Social avoidance.	+Arousal Management; Behavioural Activation; **Relationship management
19	Ran away from home age 11 years. 'Kicked out' of Family home at the age of 19 years. Loss of young sibling and felt excluded.	Suicidal. Avoidant of emotion.	Building a new relationship with the past; Self compassion; +Emotion Management
20	Long exploitative and abusive marriage plus racial bullying at work.	Stress, chronic hypertension. Relationship difficulties.	♦Arousal Management; +Emotion Management; Positive Anger Work; *Aspects of Self

Mindfulness is the core intervention; it informs the application of the others.♦Arousal Management includes Relaxation Breathing and lifestyle adjustment.
+Emotion management includes facing, expressing and letting go of emotion.
**Aspects of Self is mindfulness managed subpersonality work.*
***Relationship management includes assertiveness.*

Table 1.
Case table.

sector. She related that she was proud of herself for managing to make the break, and enjoying her new career and receiving recognition for her abilities and achievements after years of being undervalued and bullied. However, many stresses remained. The course was demanding, both physically and mentally. She was a single parent.

However, she was left with a legacy of chronic hypertension and sleeplessness from long endurance of bullying and control in both work and marriage. This left her exhausted and reporting low energy levels and lack of self-confidence. Furthermore, a recent serious road traffic accident exacerbated her distress and lack of wellbeing, leaving her with chronic pain.

Relations with her ex-husband were another major source of stress. As she had previously had a high income and he was on statutory benefits. Celine felt he was trying to extract as much financial advantage as he could. However, she had experienced a major financial impact after her career change resulting in financial worries and anxiety.

She also experienced ongoing, realistic, anxiety that her ex-husband's cynical bid for custody of their daughter, she was able to recognise that this was unrealistic but she felt overwhelmed and stressed over child access arrangements. Her traumatic experiences left her universally mistrustful of people, meaning she was cut off from support and warmth from her two, surviving, older children and her friends.

3.3.3 Formulation

Her feelings and emotions were validated accordingly and her chronic hypertension and insomnia were discussed as understandable in light of long endurance of bullying and controlling former employer and marital problems. The intrusion of past sense of threat compounding current adversities was explained using the States of Mind diagram (**Figure 1** above). We worked collaboratively to make sense of her presenting problem using the CCC formulation diagram (**Figures 2** and **3**) which labelled the feelings of loneliness and mistrust; anxiety, regret and sadness at its heart. These emotions were understandable in the light of her current stressful situation and the car accident, but the loss of her son and the years of bullying and abuse were still active in her life, exacerbating the hypertension and mistrust.

The other legacy of the past that was interfering with life in the present was mistrust of people and avoidance of getting close. The trauma of the loss of her

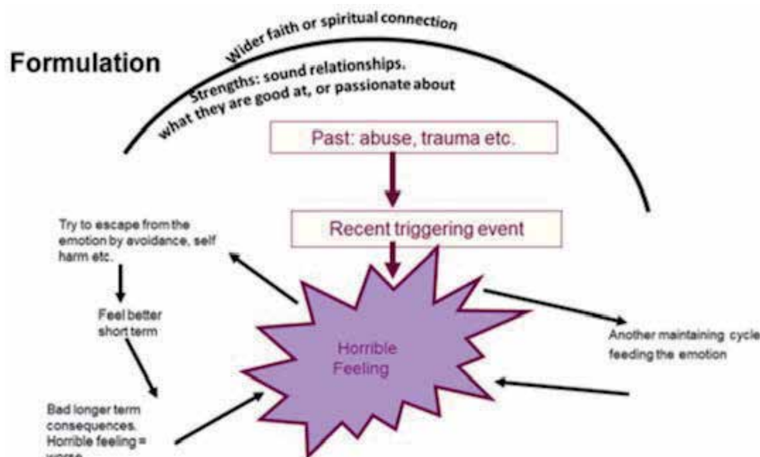

Figure 2.
Spikey formulation diagram. From Clarke & Nicholls (2018). Reproduced with permission from Hodder & Stoughton ltd [66].

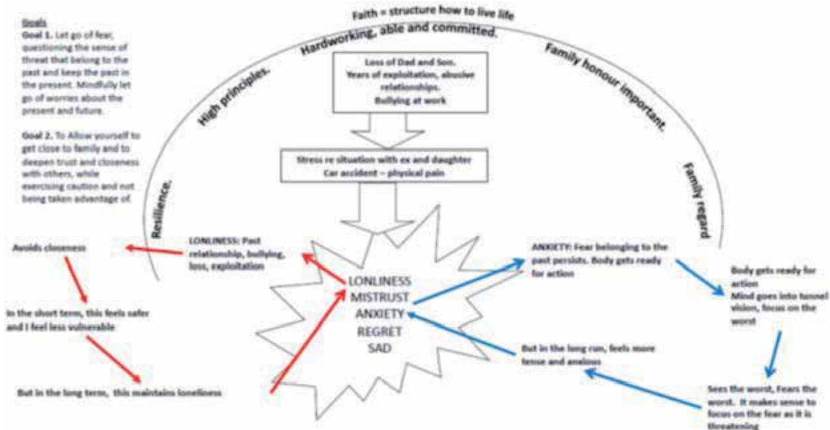

Figure 3.
Celine's spikey formulation.

son interfered with closeness within the family, so that, for instance, she avoided hugging her eldest child, which was a source of pain to both. This reticence also affected relationships with her other children and her friends. Long experience of bullying at work and the behaviour of her ex-husband made her highly mistrustful in relationships in the wider world, but at the same time, sapped her ability to be appropriately assertive, and so defend herself.

We identified Celine's many strengths; she was resilient and had high principles. She was committed, hardworking and able. She was held in high esteem in the extended family and family honour was important to her, as was her Christion faith which gave her the structure to live by.

We then identified the two major vicious circles that kept her trapped in the past, despite having broken free of abusive marriage and job through heroic effort.

3.3.4 Vicious circle 1

The fear she had lived with for so many years combined with current anxiety to maintain her body in a state of hypertension. This in turn oriented the mind to fear so that she always expected the worst, which maintained her stress levels.

The intervention following formulation was informed by goals agreed as the means to break the hold of the vicious circles, as follows:

Goal 1. Let go of fear, questioning the sense of threat that belongs to the past and keeps the past in the present. Mindfully let go of worries about the present and future.

- Face and accept that what happened did happen. Let it remain in the past.
- Be aware that the future will feel more threatening because bad things happened in the past. Mindfully note this and let go of it.
- Do this in a spirit of 'floating not fighting'.
- 'Floating not fighting' refers to the tendency of perfectionist people like Celine to approach challenge in a tense, 'fighting', mode, which paradoxically maintains the dominance of the Emotion Mind. Relationship with the body and how it is held is central within CCC because of the message that this sends to the mind – in this case, a message of relaxed strength.

3.3.5 Vicious circle 2

The other cycle tracked the way that long exploitation and bullying, combined with the loss of her son, had made her mistrustful of relationships and avoidant of closeness. This avoidance felt safer, so was maintained, but kept her lonely and unsupported. It was particularly undermining of her relationship with one of her children whom she did not dare hug as this brought back the loss of her daughter. It also caused distance from her other children.

To break this cycle we agreed **Goal 2** would focus on the following:

- To allow yourself to get close to family and to deepen trust and closeness with others, while exercising caution and not being taken advantage of.

The formulation phase was concluded with a compassionate letter, shared in Session 4 that summed up the formulation and the agreed goals of therapy.

3.3.6 Intervention phase [session 5–8]

We worked on breaking the first cycle by using breathing and mindfulness techniques in the short term. Celine was receptive to therapy and responsive to the use of mindfulness to enable her to observe and revise habitual patterns, and this brought a regular practice into her routine.

As the therapy progressed we did more work using emotions positively through mindfulness. This laid the ground work for rebuilding a new relationship with the past self. Self-Compassion is an important intervention, both to ensure that she was giving herself the best chance in the present, and in order to apply compassion for her past self, to enable her to accept and go forward from things that had gone wrong in her life. Positive anger work was also crucial here, in order to give her the courage to face the legacy of fear, without getting tangled up in bitterness. Targeted mourning enabled her to meet and let go of the sadness of all that had happened. Thus she was able to construct a new relationship with the past, facing it without letting it rule her. We never explored it in detail.

We used mindful awareness of the internal barriers to the impulse to hug to question and reverse them. Being able to hug her daughter proved something of a breakthrough, which she was able to translate into warmer relations with the wider family and friends.

3.3.7 End of therapy and clinical outcomes

By the end of therapy, Celine reported feeling more relaxed and able to take control of her life. In 'Aspects of Self-Work'[1] we did, she gained a sense of being able to use mindfulness to balance her confident, lonely persona that kept her separate, with her more gregarious and family oriented side, which had seen her exploited and bullied by others in the past. Paradoxically becoming more assertive with her ex-husband improved the relationship considerably.

Letting go of mistrust of people outside the family, born of her employment experience, was work in progress, but she knew how to proceed with it. Similarly, she had managed to reduce her ongoing hypertension significantly, but there was still progress to be made. This is in line with the philosophy of CCC, which takes the view that, once the formulation has been collaboratively arrived at and goals arising from breaking the cycles agreed, the rest of the therapy provides a tool kit of strategies, some of which will be successfully applied with the support of the therapy, but which the individual can continue to work with, helped by natural supporters, long after the end of therapy.

Celine's routine outcome measures on PHQ-9 and GAD-7 scores presented in **Figure 4** below are indicative of the progress she has made in this treatment. The spike in the graph December 2018 represents the coincidence of a bereavement, Christmas holiday, course and family pressures and was resolved by the next session meeting in January, with progress maintained at follow-up with GAD-7 scores significantly reducing to 7 at follow-up time point.

3.4 Case Example 2: Jade's journey through services

Jade was a 44-year-old married woman with two children, a 9-year-old boy and a 4-year-old girl. She grew up in the Seychelles and moved to the UK in her early adulthood to train as a teacher, leaving her family home and mother in The Seychelles. Due to the information she provided during her psychological assessment, which detailed traumatic experiences, and using the ICD-10, she was classified under the F43.1 Post-Traumatic Stress Disorder problem descriptor. Although with reference to the current ICD-11, she may have been classified under the 6B41 Complex Post-Traumatic Stress Disorder.

She defined her main problem as low mood and difficulty coping with her physical health issues (including chronic pain). "The low mood is to do with my past which I wish I could get out of my head and causes inactivity, depression and anxiety." She was recruited from the IAPT service's waiting list to take part in the Culture Free study as she met the inclusion criteria and consented to take part in this study. In line with the study protocol, she commenced a course of 12 CCC therapy sessions during the study period.

3.4.1 ***Initial therapy session*** *- Jade's background and current.*

During the first therapy session, Jade was encouraged to talk about what was not working in her life at the time. Using open ended questions and active listening, an exploration of her current difficulties and how these affects her life and relationships. Information about her early experiences and how these might impact on the current problem was also gathered.

Jade grew up in a single-parent household with what she described as "a strong and critical mother," who prided academic achievement overall and any deviation from this focus was met with physical punishment and critical verbal abuse. When Jade was 4 years old, she would spend time with her grandmother, but was sexually abuse by her male cousin during these visits to her grandmother's house. She told her mother of this sexual abuse, but her mother physically abused her

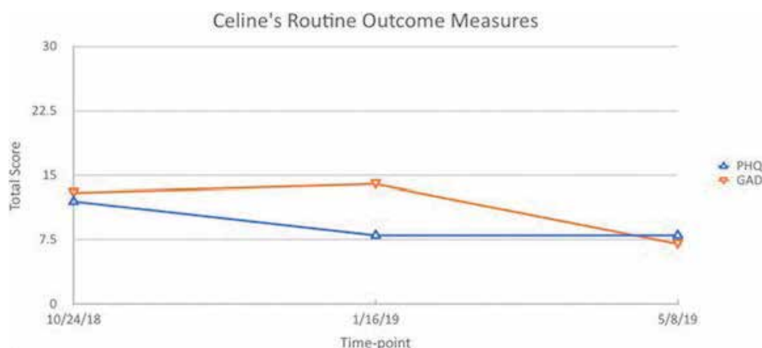

Figure 4.
Routine outcome measures: PHAQ-9 and GAD-7 scores.

and blaming her for provoking the cousin into these acts; although she never went back to her grandmother's house again.

She attributed this history as the cause of her current feelings of sadness and anger, as she thought about it often and wished she could stop these ruminations. Additionally, she discussed how having a punishing mother who expected academically high achieving children has made her self-critical and perfectionistic, which had an impact on her relationship with her health conditions. Her experiences of having fibromyalgia were also conveyed, specifically how this health condition affected her ability to do everyday tasks, such as housework, childcare and cooking. She expressed feeling guilt and shame regarding her reliance on her husband to assist with these duties, and often wished that her body functioned as it did when she was younger. This also led to feelings of sexual inadequacy and desired a "proper" relationship with her husband.

Validation was expressed regarding her current situation and emotional experiences in light of her history and current ways of coping. The states of mind diagram in **Figure 1** above was also explained to Jade using examples that she had shared to help her understand how her emotion mind memories were being experienced in the present, and also why she attempted to avoid feeling emotions by withdrawing and disconnecting with others. These psychoeducational interventions offered a normalising and validating explanation to her experiences and is an important part of CCC as it aids the person-therapist collaboration by establishing a warm and trusted therapeutic relationship, especially in cases such as Jade's who have experienced invalidating and neglectful relationships in the past. This validating, non-pathologising stance was adopted throughout therapy. Additionally, short mindfulness exercises were practiced from the start with a simple grounding, noticing practice being shared in the first session. Mindfulness continued to be introduced in each session throughout therapy.

3.4.2 The formulation

Figure 5 below illustrates Jade's spikey formulation diagram, that was collaboratively arrived at during sessions 2–4 and summarised Jade's past and current situations in a concise and clear manner. The formulation was started with the "spikey" in the centre, which focuses on the felt sense of the person. For Jade, this was sadness, anger, feeling "useless," shame, guilt, and anxiety. Situations where these feelings were triggered were explored next (the box above the spikey), and in the top box, her past

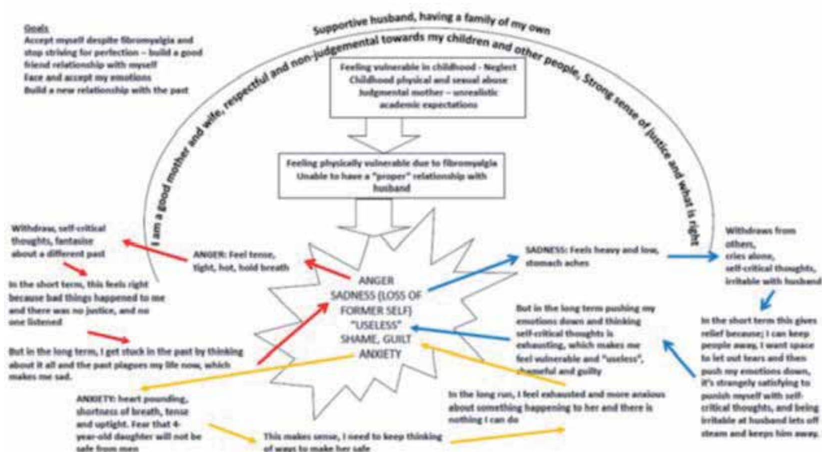

Figure 5.
Jade's spikey formulation diagram.

experiences were summarised in a way that both of us understood without too much unnecessary detail. Together, the diagram was evaluated and validation for her current felt sense was shared in light of the past that has led to a sensitivity to the triggers. Next her strengths were explored and are detailed in the two bowed texts at the top of the formulation diagram; she was proud to be a good mother and wife, with a strong sense of justice, respectfulness and was non-judgemental to her children. She also drew strength from having created her own loving and supportive family. Next her vicious cycles were explored, Jade chose to address her anger, sadness and anxiety and on each in turn identified the physical experience of the emotion, what this feeling led her to do, the reinforcer to managing the emotion in this way, and the consequences of coping in this way that keeps her stuck with the difficult emotions in the "spikey."

Her goals stated in the formulation diagram above were collaboratively arrived at from Jade's own ideas of what she wanted to achieve throughout therapy and also the therapist's understanding of the interventions that would aid a new ways of coping that might aid the breaking of the vicious cycles. These goals informed the interventions and the remaining therapy sessions.

3.4.3 Interventions

3.4.3.1 Managing your body's safety system

The CCC module entitled "managing your body's safety system" was covered with reference to the states of mind diagram and her individualised formulation diagram. This involved using specified examples applicable to her way of coping with responses for threat (fight, flight and freeze). Grounding mindfulness was an important intervention to help stabilise Jade and help her to feel safe in the present moment. For Jade this involved identifying that her threat system was being activated by triggers of her anxiety, anger, sadness and shame. These were based on the ways she had learned to manage her emotions as a child through her experiences of abuse and neglect, by covering up the fear of being punished by her mother. When Jade was younger, this was perceived as a sign of "strength" that acted as a reinforcer for being self-critical and perfectionistic, but as she grew older, she realised that this "strength" had made her miserable and disconnected from others.

Additionally, and specific to Jade's experiences of fibromyalgia, gaining an honest appraisal of her somatic experiences of her emotions, rather than overriding them, was key to her validating and accepting her emotions, which also aided the management of her pain and energy levels.

3.4.3.2 Your relationship with yourself

Self-compassion features heavily within the CCC programme and was addressed with Jade. Self-compassion, and becoming a good, honest friend with oneself, was explained as a way to break vicious cycles that featured self-criticism, which were evident in Jade's formulation diagram. This was initially tricky for her, especially the self-compassion mindfulness practice. She experienced a sense of dissociation from the feeling of welcoming herself as a person in need of care, love and protection. However, with practice in therapy and on her own between sessions Jade began to experience herself with a sense of worthiness.

3.4.3.3 Using anger positively

Within the CCC programme, anger is pitched as a very useful emotion that can facilitate action where sadness has kept people stuck. For Jade, she often suppressed

anger and withdrew from others when she felt angry. By acknowledging that anger was an emotion that alerted her to injustice, she began noticing situations where she was being taken advantage of or treated as undeserving, which she could .

Mindfulness of a strong centre was practiced alongside this module in order to instil a sense of being the observer of the situation and your own emotions without dissociating from the emotional experience.

3.4.3.4 Building a new relationship with the past

The states of mind diagram in **Figure 1** was used again to frame her emotional experiences of the past in terms of how memories is understood from the two ways of knowing; emotion mind knowing and reasonable mind knowing. The formulation diagram was also used to highlight how the past can be brought into the present by the person by them going around the vicious cycles and drawing in the past relevant to the emotion.

Mindfulness of an emotion and self-compassion helped Jade to accept the past, instead of fantasising of a preferred scenario or becoming self-critical about things she wished she had done differently.

Jade also made a connection between her own experiences aged 4 and her own daughter reaching that age, and her anxiety regarding keeping her safe from potential sexual abuse. This was acknowledged as an understandable fear, that Jade was doing all she could to keep her safe, and that she could work on reducing this fear with the use of long outbreath breathing and grounding mindfulness.

Towards the end of therapy, Jade shared that she had confronted her mother about her past. Although her mother did not acknowledge what she had to say and continued to be critical of her, she was satisfied that she had spoken her truth to her mother. She attributed the self-compassion and anger work as important in her being able to confront her mother and accept that she was not capable of being the loving mother that she wished she could have been, in a sense she had accepted the loss of the ideal mother.

3.5 End of therapy and clinical outcomes

At the end of therapy Jade reported feeling a sense of achievement that she had worked towards the goals from her formulation diagram. She felt that she had accepted herself, was less perfectionistic within the home, and more accepted of help from her husband. She had faced her past and accepted her relationship with her mother. She also felt that she was more in control of her emotions. This was reflected in her PHQ and GAD scores **Figure 6** below which shows a reliable recovery with both outcome measures. PHQ-9 score at baseline was 20 and reduced to 10, under the clinical cut off. GAD-7 score at baseline was 14 and reduced to 7 at the end of therapy.

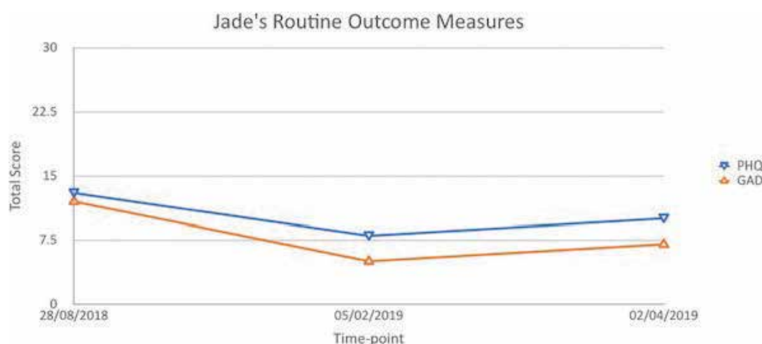

Figure 6.
Routine outcome measures: PHQ-9 and GAD-7 scores.

4. Conclusion

This research project has facilitated the development of a therapist's manual for working with cultural diversity in psychotherapy. Many aspects of cultural learning have been identified and used to develop this manual and evaluate it by therapists involved in the study. The study therapists reported that the CCC formulation was simple, effective, and validated the participants' experiences well. Whereas therapy drop-out rates among ethnically diverse populations are generally higher than for the general population, this study's retention rate of over 90% demonstrated the acceptability of this adapted intervention. A recent study of referrals to IAPT services by Baker [67] found that, compared to people from White British backgrounds, people from most Black, Asian and Minority Ethnic (BAME) groups were more likely to drop out of therapy (46% of white service users complete treatment in comparison to 40% of Asian service users). It was therefore agreed that the interventions were acceptable to participants and led to real concrete changes in behaviour.

Therapist's feedback was also used to evaluate and develop the manual for further studies and practice guidance. It was key to note that balancing Western and traditional cultures within the family is an important aspect that has been managed with mindfulness of emotions and self-compassion as well as exploring the development of interpersonal skills. Moreover, where religion is concerned, it can provide a source of strength and comfort as well as a sense of divine retribution. This challenging conflict can be explored with the individual by both validating their religious faithfulness and practicing self-compassion mindfulness exercises. The CCC conceptualisation of faith in terms of an experience of relationship with the divine opens the way to discussion of this relationship, where it is proving problematic, in ways that side-step religious dogma. Acceptability of therapy was assessed using the Patient Experience Questionnaire with overall experience rated high.

The study is also interesting in demonstrating the spectrum of trauma and past adversity contributing to current mental health difficulties across a primary care sample not selected for trauma. It further demonstrates the effectiveness of a structured way of working with trauma, using emotions positively, and drawing on identified strengths going forward, that does not entail reliving or detailed exploration of the trauma or past adverse events. This way of rebuilding a new relationship with the past is illustrated in both the case examples. By-passing detailed exploration of the past is useful, as reliving, though effective for many, can be unacceptable or inadvisable for a substantial minority of trauma sufferers. This element of CCC is as yet merely noted anecdotally and has not been systematically evaluated. Such evaluation awaits a future study.

The Culture Free study found that CCC was both feasible and acceptable in diverse populations, echoing existing research on cultural adaptions which found use of mindfulness to be accepted and appreciated as an effective intervention that can elicit concrete positive change across a broad range of mental health presentations, including trauma and trans-diagnostically. Further investigations utilising a robust methodology and powered sample are warranted in particular with diverse populations presenting with complex trauma.

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Conflict of interest

All authors declare no conflict of interest.

Ethical statement

The authors have conducted this research in relation in accordance with Good Clinical Practice (GCP). Favourable ethical opinion was obtained from London-Camden & Kings Cross Research Ethics Committees Ref: 16/LO/1899.

Appendices and Nomenclature

Session 1. Listening. Introducing the States of Mind. Introducing mindfulness and/or breathing
Session 2. Collaboratively creating the formulation diagram
Session 3. Negotiating goals for therapy based on what is needed to break the vicious circles
Session 4. Sharing the draft compassionate summing up letter and looking forward to what to work on through the group programme
Sessions 5–8/12
Goals based interventions aimed at breaking the cycles. Mindfulness is the core intervention and the following are employed as indicated by the formulation:
Arousal Management, including Relaxation Breathing and lifestyle adjustment to reduce chronic stress.
Behavioural Activation
Emotion Management includes facing, expressing and letting go of emotion
Self-compassion
Aspects of Self; mindfulness managed subpersonality work.
Relationship management including assertiveness
Building a new relationship with the past.
Follow up two months after end of therapy.

Table 2.
Appendix 1 CCC schedule of sessions.

Intervention
Mindfulness is the core intervention; it informs the application of the others.
Arousal Management (relaxation breathing etc.)
Behavioural Activation
Facing, expressing and letting go of emotion
Self-compassion
Positive Anger Work
Aspects of Self (mindfulness managed subpersonality work)
Relationship management including assertiveness
Building a new relationship with the past

Table 3.
Appendix 2 principle interventions post formulation.

Author details

Peter Phiri[1,2]*, Isabel Clarke[2], Lydia Baxter[2], Kathryn Elliot[2], Shanaya Rathod[2] and Farooq Naeem[3]

1 Primary Care Population Sciences, Faculty of Medicine, University of Southampton, UK

2 Southern Health NHS Foundation Trust, Southampton, UK

3 Centre for Addiction and Mental Health, University of Toronto, Canada

*Address all correspondence to: peter.phiri@nhs.net

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