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Highlight

ENCOUNTERING EHRENBERG: TRACING THE DEVELOPMENT OF PSYCHOANALYTIC THERAPY AT THE INTIMATE EDGE

Christine Laidlaw, M.A. ClinPsych and Shelley Heusser, M.A. ClinPsych

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Encountering Ehrenberg: Tracing the Development of Psychoanalytic Therapy at the Intimate Edge

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This article illustrates the thinking-through processes and clinical applications of D.B. Ehrenberg's ideas within the therapeutic situation. During the last four decades, Ehrenberg has articulated that the psychoanalytic relationship is at its most compelling when it evolves at "the intimate edge" of the therapist's self and that of the patient. She invites us to explore and process the relational dynamics of the therapeutic dyad within the consulting room. In tribute to Ehrenberg's work, we reflect on two individuals closed up in their self-reliance, who start to break open to their desires for intimacy when their therapist opens up his own self within the uniquely meaningful space co-created in the analytic therapy.

KEYWORDS: affective engagement; countertransference disclosure; Ehrenberg; relational psychoanalytic therapy; the intimate edge

INTRODUCTION

For a long time the notion of intersubjectivity was disregarded in the psychoanalytic community. Patients were treated according to ideals of technique that specified anonymity, abstinence, and objectivity. However, since the 1980s, there has been a revolutionary paradigm shift in the conceptualisation of psychoanalytic technique, largely influenced by Greenberg and Mitchell's concept of the relational matrix (Greenberg & Mitchell, 1983; Mitchell, 1988), where the classical one-person view of transference is superseded by a two-person view of the therapeutic situation. Within the realm of Relational Psychoanalysis, Darlene B. Ehrenberg, in her seminal work titled *The Intimate Edge*, redefines the locus of

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therapeutic action as occurring at the intimate edge of the analytic couple. She defines the intimate edge as

> the point of maximum and acknowledged contact at any given moment in a relationship without fusion, without violation of the separateness and integrity of each participant. Attempting to relate at this point requires ceaseless sensitivity to inner changes in oneself and in the other, as well as the interface of the interaction as these occur in the context of the spiral of reciprocal impact. (Ehrenberg, 1992, p. 33).

Ehrenberg's quote captures how the individual's struggle becomes one of maintaining connection to others while simultaneously differentiating from others. Working at the intimate edge is thus about clarifying the patient's desire, and the dread against it, as experienced in the context of a relationship to an Other. Thus, it is not the patient's internal dynamics alone that need to be analyzed, but also the relational configurations in which their resistances to connection emerge, as well as the individual's (in)capacity to integrate different ways of connecting that stand in dialectical tension to one another (Mitchell, 1988).

The borderland between patient and therapist is thrust into the focal arena of therapeutic action, where the quality of contact between patient and therapist is affectively communicated. Most important, working at the intimate edge does not imply that the strictures of an asymmetrical therapeutic relationship are reversed, but that distance and differentiation can be identified and highlighted. This aspect of Ehrenberg's working at the intimate edge will be explored in more detail later, as will the way in which her concept compares to and differs from other influential thinkers in the field of contemporary psychoanalytic psychotherapy.

THE ROOTS OF THE THERAPIST'S VULNERABILITY

With the "intimate edge" (Ehrenberg, 1974, 1992) in mind, Ehrenberg (2004) invites us to see her as Darlene the graduate student. She unpeels layers of herself to the reader by exposing her vulnerability, such as how, after experiencing conflicts in her intimate relationship, she travelled by train to grieve in her mother's arms. Once there, her mother held her with no words.

Decades later Dr. Darlene Ehrenberg finds herself as a therapist with brokenhearted people as clients, and draws on the manner in which her mother implicitly sensed her pain to offer a compelling way of working psychotherapeutically; that of us needing to find and provide our patients with the gift of wordless knowing.

Until recently, when confronted with the searing pain of human

messiness therapists have upheld their role as wise, detached, and neutral. The notable Object Relations concept of the entwined baby-mother remains chasms apart from the one-step-removed stance taken by some therapists who tenaciously hold onto wordy interpretations as the holding balm. From a more contemporary relational point of view, "a good-enough mother" (Winnicott, 1953, p. 98) feels her infant's pain, and she not only uses her warmth to soothe, but she is engaged, real, and truly herself. At the time of her distress, Darlene specifically sought out a personally meaningful holding, her mother's holding. Darlene's mother had carried her in a wordless incubation for nine months, and in turn, Darlene grew to know her mother from within these uterine walls at the most cellular level. Darlene has been inside this woman, who, as a girl, was "holocausted." Unconsciously, Darlene knew her mother/girl-mother and knew that her mother knew what she needed at the rawest moments in her adult life.

Just as Darlene's mother was able discern while comforting her daughter, we have found that when we work at the intimate edge, we need to be highly sensitive to the psychic changes that take place at the interface of our interactions with our patients. These interactions are defined by a helix of reciprocal, and often wordless, influences. Benjamin (2004) refers to this kind of affective resonance as the "one in the third" (p. 16), a kind of accommodation to a reciprocally influenced set of expectations in which each party surrenders a part of his or her subjectivity while simultaneously trusting that each can stay connected to the Other's mind. Ehrenberg and Benjamin both posit that the therapist's subjectivity is crucial to this wordless knowing, for she communicates her intention to surrender to the process of providing affective resonance, and without this surrender she would feel coerced or pressured to act in an accommodating manner. For Ehrenberg, working at the intimate edge means clarifying this kind of breakdown or complementarity (Benjamin, 2004) when it occurs by opening the affective interchange between patient and therapist for exploration. As such, there is a mutual creation, at least temporarily, of a potential place where difference can be enjoyed, rather than perceived as destructive or obliterating.

Ehrenberg's own experience of holding with her mother is arguably a critical factor that influenced her theory and clinical practice. Ehrenberg's compelling recollection of her mother's wordless knowing of her pain refutes the idea that the therapist needs to verbally self-disclose to achieve a state of mutual recognition. Rather, Ehrenberg's mother communicated her subjectivity in an entirely different way. In this type of holding, she conveyed her intention to surrender to her daughter's emotional world. As

the daughter receiving comfort, Ehrenberg was not oblivious to her mother's surrender; it was the felt sense that her mother was willing to be impacted by her that allowed the daughter to trust that she could remain connected to her mother's mind in this wordless holding. This is different from feeling coerced to respond in a particular way. This example also illustrates that shifts occur in the analytic pair without interpretation.

As relational psychotherapists, we attempt to understand what is going on inside the patient through the use of our own subjectivity, that is, our own bodies, thoughts, and feelings. However, this differs from the way in which, for instance, Object Relations theorists understand and use the countertransference. The Object Relations therapist uses her countertransference to comment on the patient-therapist relationship from outside of the interaction. As such, the therapist remains the expert by virtue of her knowledge of the patient, putting the patient in a position of either agreeing or disagreeing with the meta-communication. In contrast to this, the intimate edge is a *process* which the therapist together with the patient inhabits and moves with. From this perspective, the patient cannot be known from the therapist's point-of-view; rather the therapist climbing inside of their interaction, and analysing this from the inside out, becomes both information for their process and the vehicle of the process (Ehrenberg, 1992).

LOOSENING UP THE TERM COUNTERTRANSFERENCE

Initially, predatory and potentially explosive connotations were attributed to the therapist's own subjectivity (Freud, 1910). Countertransference was seen as a threat to effective treatment, and thereby the therapist was forewarned to guard against putting her unique personhood in the room. Through Heimann (1950/1989) and Racker's (1957) work on complementary countertransference and concordant countertransference, a less defensive "on guard" position by therapists was taken towards countertransference. Countertransference needed to be recognised as an inevitable and integral aspect of the therapeutic engagement between patient and therapist. From an object relations stance, therapists were encouraged to identify and use their feelings towards understanding the patient's unconscious to inform the patient's treatment.

As such Object Relations therapists have used projection identification as the solution to their own affect. Yet through a conception of countertransference as projective identification (Klein, 1946/1997), the patient is redefined as a conjurer and the therapist as merely an innocent bystander who is pulled in against her will, which leads to therapists, often indig-

nantly, claiming (after being in an entanglement) "the patient put this into me and I must feed it back to them."

Yet, Ehrenberg takes the idea of countertransference further than merely a tool to effect change for the patient. She, alongside other relational psychoanalysts since the late 1970s, argued that the term countertransference assumes that it is hinged first upon the transference of the patient. This smacks of wishful thinking on the part of therapists. When it comes to intimately engaging with each other, the subjectivity of the therapist is as vulnerable and under the glare as the patient's subjectivity. Countertransference is not only the creation of the patient within the therapist, but countertransference is also a cocreation, just as transference is a cocreation between both therapist and patient (Jaenicke, 2007; Orange, 1995), and as such, therapy involves co-transference between two individuals. Both individuals' subjectivities slip and slide under the pull of relating. And, at times, the only thing which can be relied upon in the encounter is the grasping reflex of the therapist to make sense of what is happening. But the therapist's turning to look into her subjectivity is by no means superiorly exempt or safely quarantined from the entanglements of the therapeutic endeavour, as the looking-into rests within the mutual heat of the moment. The therapist, too, invites the patient to tune into and express their subjectivity. Mutual reflection on one's subjectivity cannot be barricaded from the mutual experience.

One gets the sense in Ehrenberg's writings that the countertransference is not something that can be thought about, as Object Relations theorists would suggest. It arises in the cocreated moment born out of two people interacting at an edge at which their impact on each other becomes clarified. Work at the intimate edge cannot be taken for granted; it requires an active effort and curiosity on the therapist's part to make visible interactional issues that need to be addressed and spoken about. This dynamic encounter is not arbitrated by a third which only the therapist can understand. Work at the intimate edge constitutes a joint process of understanding. Ehrenberg's willingness to focus on the therapist's subjectivity essentially challenges therapists to take full personal responsibility for their feelings and vulnerability, which enables them to transgress their own defensive operations and meet the other individual, their patient, at the intimate edge.

Inviting the patient to explore collaboratively what is going on not only inside of him but also inside of the interaction is in itself transformative, as it creates a context in which the complementary twoness of expert–patient, knower–known is displaced in favour of a more intersubjective system that

acknowledges the patient's agency and relieves their sense that the problem lies with them (Ehrenberg, 1992).

The process of achieving this kind of thirdness is similar to working at the intimate edge, where there is an unpacking of the positions of complementarity (or doer-done-to dynamics), which forecloses the establishment of a space in which tension and difference can be straddled (Benjamin, 2004). Both Benjamin and Ehrenberg understand breakdown as occurring when the tension between self-assertion and recognition caves in. Ehrenberg, however, is more frank about the way in which she breaks such impasses. She not only insists that patients share their immediate responses to the therapist's actions, but by clarifying her position in the interactional dance, she emphasises the need for the patient to recognise the therapist as a person in her own right, a "like subject," who will not be controlled, manipulated, or coerced. The mutual exploration of how, when, and why the patient and therapist attune to each other, respond to the other's needs, or frustrate each other, becomes the vehicle for transformation.

In a similar vein to Benjamin (1988), Ehrenberg challenges the negation of the mother or therapist when the need of the patient is in the foreground. Both Benjamin and Ehrenberg argue that the subjectivity of the therapist needs to be acknowledged and seen as mutually valuable for the relationship and for the self of the patient. A relational therapist does not merely understand, interpret, and conjure up wisdom for the distressed individual. We allow ourselves to encounter our blind-spots, and in so doing allow our patients to encounter who we really are, warts and all. As a result, we begin to glide to the intimate edge, whilst allowing our patients to meet us at the cusp of this form of relatedness. Nonetheless, the professional mask of composure and the attendant stance of objectivity and "expertise" have an allure that is hard to forego.

Indeed, if Ehrenberg does not overvalue interpretation of the patient's internal world, what does she do in the therapeutic situation?

ABANDONING THE "ONE-STEP REMOVED" COMPOSURE

If you prick us, do we not bleed
if you tickle us, do we not laugh?
(The Merchant of Venice, Act III, Scene 1,
Shylock to Salarino, William Shakespeare)

Ehrenberg (1995b, 2006) argues that there is no such thing as an impenetrable statue-like therapist or an innocent, immune, and objective participant, that such a position is deceptive, and can have potentially

destructive consequences for the therapeutic encounter. As Hoffman and Aron (1996) pointed out, the therapist's subjectivity is irreducibly involved in continual unconscious interaction with the patient. Thus, attention needs to be paid not only to the patient's experience of the therapist, but also to the therapist's participation in and impact upon the dyad. The patient's internal object world inevitably coalesces with the therapist's, and this needs to be played out and lived out, as opposed to merely interpreted. Within such exchanges Ehrenberg (1996) draws on her emotional availability and vulnerability towards her patients, and lets them know that they have had a real impact on her not only as a transferential figure, but also as person. In paying attention to the affective interchange as it occurs in the moment, Ehrenberg (1995b) avoids heading down a one-way street of coolly intellectualized interpretations. In the spaghetti-like embroilment of mutual vulnerability, Ehrenberg challenges us as therapists to stake out the level at which we are willing to emotionally risk ourselves in relation to our patients. Thus, authenticity becomes the centre of their therapeutic approach, and vulnerability here means that the therapist works from within her subjectivity, when it matters the most.

If we allow ourselves to be seen in the garb of wizards with special, all-knowing powers we wreak havoc when in an instance of painful chaos the patient pulls at our cloak for assistance and is met with the naked reality that we are just as human as they are. In contrast, in working with a particular patient in a more affectively honest and mutual way, Ehrenberg found that her "willingness to live through these experiences with her and to treat her as a person rather than as a 'case' was what mattered most to her and made it possible for her to take the risks she did" (1972, p. 73).

Another patient found it healing that Ehrenberg (1996, p. 284) did not wear "psychic rubber gloves" and as such she aimed to come in close to touching and being touched by her patients in ways where both were left knowing what it means to be painfully/wonderfully alive with a heart of flesh. In being open to being moved and demonstrating one's willingness to lilo upon or ride out deep affect, we quell our patients' fears of opening themselves up and touching their own true self. In this sense, the therapist's countertransference becomes a valuable tool because it casts the therapist in their humanity and fallibility and in so doing not only unburdens the patient (I am like you) but also brings them closer together.

Ehrenberg asks that together, both parties remain in the thick of things, and when they cannot do so, to engage each other in reflecting on why it has become so difficult to be with the other. In other words, she invites the couple to actively explore the therapeutic stalemate (Ehrenberg, 2000).

Once we become entangled and twisted up in unconscious communication with our patients, we need to set about intentionally untangling one another (Ehrenberg, 1984, 1986).

Her "direct affective engagement" (Ehrenberg, 1996, p. 278) not only means that both participants are responsible for and fully immersed in the transference-countertransference configurations, but that the to-and-fro of these relational shifts can be shared and thus processed. A collaborative space is cleared for both participants to "unpack complex interactive subtleties" (Ehrenberg, 2000, p. 585), in that both are co-instigators of the moment-to-moment psychotherapeutic interaction. In true two-person fashion, Ehrenberg goes beyond abstinence and denial and explicitly talks about the relationship at hand by reflecting on her countertransference and opening it up to the floor (Yalom, 2001). The therapist reaches out and shares the dilemma or struggle in the relationship and, in turn, promotes the patient offering his or her interpretation as to where the relationship stands. Herein, Ehrenberg (2003, 2010) refutes the idea that the therapist can colonize the patient's internal emotional landscape with an all-knowing interpretation. Rather, she places priority on being sensitive to the unique moment between herself and the other person, and, therefore, does not foresee using a specific intervention. Ehrenberg (1992, 1995) draws on what she feels will honor the interaction between her and her patient in the moment, thinking through it, and in the instance of one patient, Majorie, an "emotionally dead" toddler, actively howling to capture her attention and to resuscitate her.

> Even when the "intimate edge" is missed and there is some kind of intrusion or of some failure to meet due to overcautiousness, the process of aiming for it, the mutual focus on the difficulties involved can facilitate its achievement (. . .). The "intimate edge" is, therefore, not a given, but an interactive creation. It is always unique to the moment and to the sensibilities of the specific participants in relation to each other and reflects the participants' subjective sense of what is most crucial or compelling about their interaction at that moment" (Ehrenberg, 1992, p. 33-35).

This quote emphasizes Ehrenberg's relational psychotherapeutic stance; its locus cannot be banished to the inside of one "sicker" individual. We need to be willing to take meaningful emotional risks with our patients in order to reach them. Whether we howl, weep, lose our temper, self-disclose, keep still, stand our ground, or apologize, our action cannot be prescribed nor proscribed unless we have climbed into the interaction and determined whether it holds the potential to be destructive or constructive to the patient, our shared relationship, or to ourselves.

Though Ehrenberg (2006) is not against techniques such as free-association per se, she speaks of the need to be aware of the distancing and defensive quality that such techniques may present to both the therapist and the patient. In this way, the therapist may use interpretation, silence, and reverie, or adhere to non-negotiable frame considerations, to remain untouched and safely removed from revealing their reactions to the patient's pricks and tickles. This could be seen as a form of defensively motivated false self functioning on the part of the therapist (Ehrenberg, 1996, 2003).

MOTH TO THE FLAME: THE THREAT OF DESIRE, VULNERABILITY, AND INTIMACY

According to Ehrenberg (1992), toxic early relationships compel individuals to close themselves off to experiencing desire. For the desire to relate requires one to place oneself in a position of alarming vulnerability that may not be attentively met by the other. The individual not only steers clear of interactions that produce shame-laden affective states, but disavows the desire for intimacy. Need, dependence and tenderness are construed as dangerous, threatening, and grounds for humiliation and rejection. However, by definition, authentic intimate relatedness must occur through vulnerability in relation to an Other, and it is this surrender that has the potential to unfreeze the individual and thaw their sense of feeling "dead," false, isolated and robotic within daily life. We believe that it is only in the context of being with a receptive Other that we come to know and be our true selves. Independence and self-reliance merely promise a brittle self.

In this light, therapy offers the fragile, frightened self a viable context in which to unfurl, awaken and enliven. The fountain of aliveness and all other attachment processes require an interpersonal context to evolve. "The 'intimate edge' becomes the 'growing edge' of the relationship" (Ehrenberg, 1992, p. 34). The "intimate edge" is thus never set in concrete; rather, it is like the tides coming to the shores, constantly in ebb and flow. When one risks coming in close, one finds not only the other but also oneself. Self-experience is built in the cradle of self-with-other experiences. A self can thus only be created within an affectively alive relationship that welcomes and houses inevitable conflict.

NEIL

I (S.H., the second author), find myself remaining in the thick of things with Neil, a male in his 30s who had a traumatic childhood history. Neil's

father abandoned him after his birth, and his mother, tightly wrapped up in herself, was unable to provide her son with the cradle for connection and intimacy. He felt used and betrayed. It was a childhood lost at the hands of greedy "takers" and abusive authority figures. His mistrust and rage towards others continued throughout his adolescence, where his male high-school peers would recruit him into their clique as "it was always easier to pick up the girls" with him around. Neil was used as bait by his peers mostly due to his status as an outsider, as well as the intriguing air of charm and confidence he carried around. However, in an effort for self-protection, Neil found himself refusing, as he did not want to be used as a prop to satisfy the needs of others.

The first phase of psychotherapy was marked by a sense of deadness. I felt caught in a tortuous meandering of words and thoughts that culminated in a sea of lifelessness and boredom. We were excluded from a mutual engagement that held the potential to feel desirous, alive, and playful.

By the eighth month of psychotherapy, Neil started repeatedly asking me what was wrong with him. At the time, I did not realize that it must have taken tremendous courage to risk asking me that question. It was something which he had never done before. Instead of answering him, I chose to interpret his requests. I asked him what he imagined me saying, and he responded, "I want to know if I am bad, if I have a problem, or if it's just the way my wife sees me." I, in turn, asked him whether it mattered what I said as perhaps he wanted to elicit a final judgment from me confirming his badness.

His question did matter to him! Yet, I missed this by choosing to remain impartial and by withholding my subjectivity. My action suggested to him that it was shameful to engage me directly.

Neil relayed that at the age of 16 he had made a list of people who had hurt him throughout his life, and he imagined how he would kill them one day. He also added he was intent on buying a gun to kill his wife's friends ("they will get what is coming to them"). He continued, "the day will come . . . the day will come." At that moment I felt pushed into a corner, trapped, and paralyzed with dread. As we unpacked the subtleties of what had transpired more closely, it emerged that Neil's powerlessness in response to my omnipotent desire to abstain from a more affective mutual kind of engagement shored up his painful experiences of being done-to by more powerful others. Furthermore, my desire to hold onto my power emerged from my implicit fear of feeling at the mercy of Neil the persecutor–a terror of being in the firing line of Neil the gunman. We were

able to explore how my unconscious refusal to engage with Neil's risky, self-exposing question, and the hurt that this had exposed him to, set up a doer-done-to complementarity in which the power dynamics had been reversed (Benjamin, 1988).

The enactment around my refusal to engage Neil, and the subsequent escalation of his murderous rage, revealed how we had protected each other not only from this hidden side of Neil, but also showed how my fear of directly engaging him, or confronting him, kept me locked in a power position that shielded me from feeling scared and unprotected in his presence. The more I stayed in this position, the more he asserted his rage, until the doer-done-to dynamics had been completely reversed. By setting a limit to his threatening behaviour, while also acknowledging the extent to which I had hurt him, we were able to move out of the impasse. We were able to open up to joint exploration our shared experience of fear, threat, and power in the consulting room. In sharing my subjective experience of the relationship, and the part that I had become aware of playing, we moved from a state of reacting to a space in which we could both hear each other and tap into those dissociated parts of ourselves that precipitated the breakdown.

When Neil and I caved into impasse, he felt as if the claim to thinking about our relationship was mine alone. My way of seeing him was the official one; the only one (Benjamin, 2004). His insistence to know what I thought of him not only attested to the fact that I had become the omnipotent, unyielding wizard, I had also hidden behind this part to protect myself from acknowledging that I was playing a more sadistic role. It was when we were able to recognize that I had recreated an earlier wound of his and mine that the complementarity dissolved (Benjamin, 2004), and he was able to express his hurt and shame more openly.

In the following session, Neil said, "I don't like it that I always need to know what people think of me or expect from me. But I do it because I don't want them to think I am bad." He went onto to describe how a builder always needs to know exactly what tools are required before he can even remotely begin to build a house. I understand this as Neil's need to have his anxieties and fears known by me before he can even begin to risk building a trusting connection with me.

Now, eighteen months into his therapy, Neil still huddles in his hole, afraid of hurting and being hurt. However, following the deconstruction of our mutual enactment the initial deadness in our process has given way to an intensified feeling of closeness and spontaneity. He is also gradually risking the degree of his vulnerability in tandem with my growing affection

towards him. Recently, Neil has tenderly remarked, "You remind me of my best friend . . . the emotional connection is there."

Actions Speak Louder than Words

> It is a very remarkable thing that the unconscious of one human being can react upon another without passing through the conscious (Freud, 1915, p. 194).

Freud, in discovering the talking cure, found that it is the felt affect-laden aspect of what the patient recalls that leads to resolution of the previously repressed trauma (Breuer & Freud, 1895). Without affect we cannot hope for a cure. However, Ehrenberg (1984) goes further and argues that it is not just the patient's affect that needs to be aroused, but also the therapist's emotions that need to be stirred. There needs to be a palpable affective interchange to kindle the healing. Slushing the affect to and fro spins the intimacy between patient and therapist.

This engagement goes beyond the more classical, rigorous techniques in which the therapist is more likely to interpret what her patients' induce in her as such, "You conjured this up in me" (Gerhardt, & Sweetnam, 2001). For instance, less relationally inclined psychotherapists do not seem to share with their patients the impact patients have on them. Ehrenberg (1992) may say to her patient, "I don't like to be threatened" whereas, the Object Relations therapist informed by projective identification might stop at, "You are threatening me." One could wonder whether an Object Relations therapist's patients ever glimpse the real person, not only who they make of their therapist. In contrast, Ehrenberg's more relationally authentic and honest use of self tends to enliven the affective tone of the interaction.

Breaking Open to Desire

Ehrenberg (2003) does not infantilize her patients in that she resists assuming an all-knowing stance towards them, nor does she coddle them by being overly warm and attuned. In her ample clinical examples, she demonstrates how she fosters self-agency in her patients by pointing out that they themselves are responsible for their actions (or for choosing to disavow responsibility for their actions). As such, she conveys that she will not be controlled or manipulated by the omnipotent needs of the patient, and thereby she portrays resilience in surviving the patient's aggression (Winnicott, 1947/1975; Benjamin, 1988). Yet, her playfulness and use of mutually enjoyed mirth affirms and bolsters the vitality of the patient and reflects the *whole* pleasant/unpleasant truth about the human condition

(Ehrenberg, 1976, 1990, 1991). However, as Ehrenberg (1992) cautions this would need to be sifted through and opened up for mutual exploration of the transference-countertransference, as playfulness can easily disguise the therapist's attempts at posturing or ridicule.

Ehrenberg (1984, 2004, 2006) demonstrates an unwavering commitment to being her real self with her patients and, if she appears inauthentic, she bears that responsibility too. This emphasis on personal responsibility conveys to patients the belief that they can function on their own behalf. Furthermore, in promoting the subjectivity of the therapist, Ehrenberg demonstrates that each is entitled to their own experience, even when it jars with the other's experience of the interaction. No person is the sole "arbiter of reality" (Ehrenberg, 2003, p. 580). Such respect for individual subjectivity counteracts the need for patients with histories of emotional violation to continue to live out a compliant self that originated in their childhood. Emotional insight lies within the patient's understanding and needs to be self-grown for insight to remain self-enhancing and transformational. Here Ehrenberg disrobes the traditional psychoanalytic therapist of their special powers–the potion of insight is not ours solely to dispense. By painstakingly staying at the intimate edge of the therapeutic encounter, the patient reaches insight on his own, and discovers resources and self-capabilities that were hidden until then. It is in the outflow of intimacy that self-capabilities germinate and thrive.

Furthermore, because our own blind spots form part of the intersubjective matrix, and these difficulties need to be negotiated relationally, our patients are enabled to examine their own blind spots without feelings of shame. If a patient is unwilling to discover their own contribution to the transference-countertransference dynamics due to shame-filled affects, then the therapist's willing surrender to our countertransference permits the patient to comfortably discover and reveal hidden feelings. This form of self-disclosure is born from the two-person dimension of the therapeutic situation and not only deepens the relationship, but also allows the patient to encounter his own real or perceived transgressions without castigation, self-reprimand, or shame (Jaenicke, 2011).

LILY

Lily, a female in her late 20s, with a history of child sexual abuse came to me (S.H., second author) for once-weekly psychotherapy. In the middle phase of her therapy, she arrived for her afternoon session in a rather irritable and aggressive mood. I wondered what was occurring between us that had brought this about, and tracked my internal response to her mood

as the session progressed. I became aware of feeling irritated and dismissive. I felt cornered. I recalled that while most of our previous interactions had been playful and spontaneous, this one seemed constricting and confrontational. I was also reminded of that part of her which she had previously referred to as "The Bachelorette." The "bitchy raging monster" part that wielded power over men and stubbed out the kindled cigarette before it started burning.

At this moment in the session, I disclosed to Lily that I felt castrated and weak, and that her sarcastic responses seemed quite hurtful. It emerged that for some time now she could not get herself to feel vulnerable *with* me anymore. She needed to convey this by falling back on her trustworthy Bachelorette. As she remarked on her need to distance herself from me, I remembered feeling a diffuse sense of irritation in earlier sessions. In the previous session I had even enacted my irritation by responding to her news of her successful participation in a sporting event somewhat indifferently. I wondered whether Lily had sensed my irritation even before she needed to call on her Bachelorette.

Indeed, my disclosure and the subsequent elaboration of her stilted vulnerability in relation to me enabled us to examine the transference-countertransference lock-down. We vacillated between victimizer and victim, winner or loser, my reality or your reality. Sharing my feelings enabled me to elaborate the impact her Bachelorette had on me, which facilitated Lily's recognition of disavowing desire and her fears of humiliation in being seen by an Other in an intimate way.

Up until that point in our process, Lily enacted the Bachelorette in her need to have me know that while she was once able to risk being vulnerable with me, she was now wounded, retreating into her cocoon. Once I was able to understand that my irritation was not related to Lily taking control of the sessions, but rather a product of my own historical anxieties around being confronted with the vulnerability of significant female figures in my life, I realized that Lily must have been convinced that I did not want to know her more vulnerable self. We were continually crashing against each other. In these crashes, we were both willing and unwilling to see each other, and heading for collision/collusion. Because we were able to navigate the experience of her anger resulting from the encapsulation of her vulnerability in response to me, Lily was able to link her Bachelorette to a sadness of a painful bullying experience as a child:

"I have to dominate others, become bitchy and aggressive, because if I don't they will hurt me . . . but then I end up chasing them away". She continued, "I feel like someone is going to come knocking on the door and

tell me that all your empathy and feeling things for me is untrue because it was all a fake, both on your part and on mine". In this instance, Lily's desire for me to feel for her was made explicit. Her yearnings for connectedness, along with her terrified expectations of loss, doom, and exploitation, became the focus in the final stages of our therapy.

As we reflected in our final sessions, Lily's desire broke open, and in her fullness she shared her metaphor with me. Indeed, her creativity is one of the many things I love about her. Through the metaphor, she described her experience of being in psychotherapy with me:

> In Kenya there's a fish that hibernates in a cocoon in the dry season. But then the rain comes and starts cracking open the cocoon and the fish slowly starts flowing down the stream created by the rain. The flow is not smooth though, and along the way it will bump into things, but eventually the stream becomes a river and it leads the fish to the sea.

DANCING AT THE INTIMATE EDGE . . . FORTY YEARS OF THRILLS

In this highly involved dance of relational psychoanalytic therapy, Ehrenberg (2003) does not resort to coercion, overexposure, or intrusiveness. She holds that an intimate relationship also needs to make room for self-definition (Ehrenberg, 1985), for the self to be private (Ehrenberg, 2003), and for the self to go into hiding, with the potential attendant desire to be come after by the other and be found (Winnicott, 1965/1990; Ehrenberg, 1992). Furthermore, she encourages the idea that the patient needs to set the pace of the interaction (Ehrenberg, 2003).

Ehrenberg's elaboration of the intimate edge can be easily misunderstood as advocating a therapeutic intimacy devoid of confrontation, which breeds sought-after, regressive closeness and warmth. It can also be misinterpreted as an ad-hoc, dicey, off-the-cuff manner of deliberately inserting oneself into the patient's psychic space. However, a careful study of her definition of intimacy reveals that it neither excludes conflict or confrontation, nor does it imply a treacherous openness to boundary transgressions on the other end of the spectrum. On the contrary, working at the intimate edge requires that the therapist be highly vigilant of and sensitive to the psychic boundaries demarcating the analytic couple.

Clarifying when the therapist's response feels colonizing or coercive to the patient, or when the therapist feels coerced by the patient, is key to the sense of personal responsibility the therapist must bear when working at the intimate edge. The intimate edge is thus about the therapist's self-delineation and attunement to the patient's ability to demarcate emotional

boundaries. It is about staying true to the perimeters of what is or is not holding the interaction together, even if this means disclosure of the therapist's personal reactions and limits. Moreover, closeness, which results from this kind of affective honesty, should not be viewed as antithetical to conflict since Ehrenberg's numerous clinical examples indicate that closeness can be achieved in the storm of conflict (Ehrenberg, 1992). The therapist's commitment to affective honesty and respect of the Other's personal, separate integrity (the "edge" in the intimate edge) transforms the potentially destructive elements of conflict into a mutually generative attachment (the "intimate" in the intimate edge). In this sense, conflict is not opposed to intimacy, it is the needle that can both pierce and stitch the fabric of the interaction.

Ehrenberg's therapeutic stance and deep knowing of the contemporary psychoanalytic endeavor has been described by highlighting key aspects, but her therapy goes straight to the heart of what it means to be a therapist. She states,

> I believe that our own willingness to risk knowing and being known, touching and being touched by another human being, may be far important than has been recognized. Perhaps our willingness to recognize the terror this holds for us, as well as for our patients, is critical if we dare to work at this level (Ehrenberg, 1996, p. 284).

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The Supervisory Alliance: A Half Century of Theory, Practice, and Research in Critical Perspective

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Over the course of psychotherapy supervision history, the supervisor-supervisee alliance has increasingly emerged as a variable of preeminent importance in the conceptualization and conduct of the supervision experience: It has come to be embraced as the very heart and soul of supervision. But after a half century, what evidence do we actually have to justify that highly favorable outlook afforded to the alliance? What do we really know about the supervisory alliance? What do we need to know about it?

As we mark the first 50 years of supervisory alliance and look toward its future, I thought it might be useful to examine those questions and provide a current status report about the construct itself. In what follows, I (a) describe the two supervisory alliance visions that have been (and remain) dominant in the supervision literature and (b) provide a review of 20 plus years of supervision alliance research. While the supervisory alliance has accumulated solid clinical support, its empirical support appears to be more tentative and less robust. I consider why that is so, identify some missing elements in the alliance research conducted thus far and propose possible remedies to move inquiry in this area forward.

KEYWORDS: supervisory alliance; supervision alliance; learning alliance; working alliance; psychotherapy supervision; supervision bond

INTRODUCTION

The relationship between psychotherapy supervisor and supervisee has long been a matter of concern in the supervision literature (Bernard & Goodyear, 2014; Falender & Shafranske, 2012). Even in some of the earliest writings about supervision, the importance of the supervisory connection, if not explicitly emphasized, appears to have been implicitly conveyed (e.g., Eitingon, 1923, 1926; Watkins, 2013a). In contemporary

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practice, the supervisor-supervisee relationship continues to be assigned a place of nuclear significance; as now conceptualized, it encompasses a host of substantive variables, including supervisory style, real relationship, transference-countertransference configuration, supervisee anxiety, and issues of difference and diversity (Beinart, 2012; Crook Lyon & Potkar, 2010; Rodenhauser, 1997; Toldson & Utsey, 2008; Watkins, 2011b). But of the various elements that compose the supervision relationship, none seems to exert more power and influence on supervisor and supervisee than their jointly-forged *supervisory alliance*.

Over the course of the last half century, the supervisory alliance—which tends to be thought of as the supervision equivalent of the psychotherapeutic alliance—has emerged as supremely significant in the conceptualization and conduct of the supervision experience (Bordin, 1983; Falender & Shafranske, 2004; Fleming & Benedek, 1964; Teitelbaum, 1995, 2001). The alliance has been increasingly embraced as the very heart and soul of supervision, and its potential impact on the supervisee change process and supervision outcome has generally come to be regarded as affecting and far reaching (Inman & Ladany, 2008; Ladany & Inman, 2012). Across psychology competency frameworks, the formation and management of the supervisory alliance has been made a core competency internationally (Falender, Cornish, Goodyear, Hatcher, Kaslow, Leventhal, & Grus, 2004; Fleming, 2012; Gonsalvez & Milne, 2010; Psychology Board of Australia, 2011; Roth & Pilling, 2008; Turpin & Wheeler, 2011). Regardless of the supervision model employed (e.g., psychotherapy-focused, social role models), form of treatment being supervised (e.g., individual, family), or type of population served, the alliance tends now to be recognized as pivotal in making the work of supervision possible (Falender & Shafranske, 2008; Hess, Hess, & Hess, 2008; Stoltenberg & McNeil, 2010; Watkins, 2012). Some supervision approaches may weigh the role of alliance more heavily than others (cf. Beck, Sarnat, & Baranstein, 2008), but its place in supervision appears to be uniformly acknowledged and accepted across varied models of conceptual understanding.

In this paper, I would like to shine a critical light on the supervisory alliance and to consider its current status and future directions. With the supervisory alliance having reached the half century mark, and being regarded as such a pivotal, transtheoretical construct in guiding supervision practice, I thought it might be a good time to "take stock" and examine two basic questions:

- What have we learned about the supervisory alliance thus far?

- What do we need to know about it for our alliance knowledge and understanding to most fruitfully advance?

I will address those questions by (a) defining and describing the two alliance perspectives that dominate supervision theory, practice, and research; (b) reviewing the supervision research that has emerged over the past generation; and (c) developing an integrative picture of the present status and future needs of the supervisory alliance.

TWO GENERATIVE VISIONS OF THE ALLIANCE IN SUPERVISION

To best understand the supervisory alliance in a contemporary perspective, it is important to first look back, examine how the construct began to take form in psychological thought, and reflect on how it came to inform our views about "good" supervision. As with so much in psychotherapy's origin and evolution, the alliance is typically viewed as having begun with Freud; that beginning also appears to have laid the groundwork for the eventual emergence of alliance considerations in supervision.

Freud's Contributions and Beyond

Although Freud did not specifically use the term "alliance" until his 1937 paper on analysis terminable or interminable, there is little question that his ongoing clinical work consistently revolved around matters of alliance. As Hatcher (2010) has nicely summarized: "Freud encountered alliance issues as soon as he began to use psychological methods with his patients. . . .we can identify as alliance issues his struggles to engage and keep his patients in treatment" (p. 8). In his writings, Freud (1913/1958, 1937/1964) made mention of the supreme importance of "a well-developed *rapport*", pact, or compact between analyst and analysand for treatment advance. As his thinking evolved, the element of collaboration came to figure far more prominently into his vision of psychoanalysis (Hatcher, 2010). Building on those seminal concepts, other notable analysts such as Sterba (1934), Zetzel (1956), and Greenson (1965, 1967) introduced the terms of alliance, therapeutic alliance, or working alliance into the psychoanalytic lexicon, and the treatment relationship became increasingly conceptualized as a type of joint relational effort or therapeutic partnership. As the idea of a treatment alliance gained traction and acceptance in psychoanalytic thought, a related question soon emerged: How might the construct of alliance also apply to the psychoanalytic supervision relationship?

The Fleming and Benedek Perspective on the Learning Alliance

In the mid-1960s, Fleming and Benedek (1964, 1966) first proposed the concept of a *learning alliance* for psychoanalytic supervision, though they readily acknowledged Freud's contributions in stimulating their own supervision alliance formulations.

> The structure of both the analytic and supervisory situations is determined primarily by the goal which each participant expects to accomplish in their work together. These ultimate expectations, whether therapeutic or educational, orient the behavior of each member and guide their interactions through many vicissitudes. Expectations of giving and receiving help initiate a bond of trust and confidence between analyst and patient without which analytic work cannot proceed. . . . In supervision there exists the same necessity for acceptance of a mutually shared educational goal and the same need for confidence that the expectations of teacher and learner can be satisfied. The term *learning alliance* describes the essential characteristic of this relationship (pp. 52-53).

For Fleming and Benedek, the learning alliance—a supervision partnership, pact, or compact—was *sine qua non* for supervisor and supervisee to work profitably together.

Their vision of the learning alliance brought into focus the necessity of key features such as supervisor empathic perceptiveness and responsiveness, creation of a state of rapport in supervision, determination of a supervision goal or goals in common, and placement of learning tasks that stimulate goal accomplishment. The primary goals that provided guidance for supervision were: (a) insuring patient care; (b) enhancing the analyst's knowledge; and (c) developing and enhancing the use of self as analytic instrument during the treatment process. Some of the learning tasks involved were: (a) the analyst/student's working up case material for presentation in supervision; (b) the supervisor's educational diagnosis of student's learning needs for remediation; and (c) the supervisor's sharing of instructive and corrective feedback. The Fleming/Benedek conceptualization accentuated, as never before, the ideas that supervision was itself a type of collaboration and the nature of that collaboration could be expected to substantially affect the entirety of the supervisory process and its eventual outcome (Watkins, 2011b). The concept of learning alliance has since heartily endured, proven quite durable down through the decades, and continues to be widely regarded as being of pivotal, nuclear significance for psychoanalytic supervision practice today (see Dewald, 1987, 1997; Frawley-O'Dea & Sarnat, 2001; Gill, 2001; Hyman, 2008;

Kernberg, 2010; Oberman, 1990; Rock, 1997; Sarnat, 2012; Teitelbaum, 1990b, 2001; Watkins, 2013b).

The Bordin Perspective on the Supervision Working Alliance

As prelude to and model for his supervision working alliance conceptualization, Bordin (1979)—building on the work of Greenson (1967), Menninger (1958), Sterba (1934), and Zetzel (1956)—first proposed a highly heuristic, pan-theoretical vision of the treatment working alliance that hinged on three crucial components: The therapist-patient bond, the collaboratively established goals that guide the treatment process, and the collaboratively agreed-upon tasks that facilitate pursuit of goal attainment. In his presidential address to the Society for Psychotherapy Research, Bordin (1980) incorporated the importance of rupture and repair events into his alliance formulations (a substantive elaboration upon his earlier proposal). While the working alliance has long been a variable of preeminent concern in contemporary psychotherapy research, Bordin's tripartite reconceptualization is credited with opening up untold possibilities for taking the alliance agenda into new and unexplored directions (Horvath, 2001); psychotherapy research across the last few decades has clearly borne strong testament to that reality (Lambert, 2013; Orlinsky, Ronnestad, & Willutzki, 2004).

Drawing on his treatment working alliance model, Bordin (1983) proposed a similar pan-theoretical vision of the supervision working alliance, which accordingly was composed of three core elements: The supervisor-supervisee bond, the collaboratively established goals that guide the supervision process, and the collaboratively agreed-upon tasks that facilitate pursuit of supervision goal attainment. As with the therapeutic working alliance, Bordin also envisioned rupture and repair events as playing a significant role in the development and maintenance of the supervision working alliance. The supervisor and supervisee bond was considered to involve their shared "feelings of liking, caring, and trusting" (Bordin, 1983, p. 36) and to "typically fall somewhere between. . . teacher to class members and therapist to patient" (p. 38). Bordin (1983) identified eight possible goals that could be used to guide supervision process:

(1) mastery of specific skills;
(2) enlarging one's understanding of clients;
(3) enlarging one's awareness of process issues;
(4) increasing awareness of self and impact on process;
(5) overcoming personal and intellectual obstacles toward learning and mastery;

(6) deepening one's understanding of concepts and theory;
(7) providing a stimulus to research; and
(8) maintaining standards of service (pp. 37-38).

He also identified three tasks by which those goals could be pursued in supervision: (a) report (oral or written) prepared by the therapist of the hour or hours to be reviewed; (b) treatment session observation through audio-recordings, video-recordings, or live viewing; and (c) presentation of problems or issues in supervision selected by the supervisee (p. 38).

Like Fleming and Benedek's conception of the learning alliance, Bordin's conception of the supervision working alliance has proven highly durable, is embraced as being of pivotal, nuclear significance in much psychotherapy supervision practice, and is increasingly heuristic in stimulating supervision research (Inman & Ladany, 2008; Ladany, 2004; Ladany & Inman, 2012).

THE TWO ALLIANCE CONCEPTUALIZATIONS IN PERSPECTIVE

Fleming and Benedek focused their alliance attention on psychoanalytic supervision exclusively, whereas Bordin (while psychodynamically influenced) proposed a pan-theoretical alliance perspective. But as is clear from a reading of these two supervision alliance descriptions, both visions are highly similar in content—invoking a shared bond or rapport as requisite, shared goals as critical, and learning tasks as mandatory. While Bordin may have identified more goals overall, the goals across both visions are alike, as are the tasks involved in their pursuit. The essence of the Fleming/Benedek and Bordin supervision alliance proposals is much the same if not identical. In my reading, I have found that Fleming/Benedek's learning alliance understandably appears far more apt to be familiar to and used by mental health professionals—particularly psychoanalysts and psychiatrists—who readily identify themselves as psychoanalytic, whereas Bordin's supervision working alliance appears far more apt to be familiar to and used by mental health professionals—particularly psychologists, social workers, and counselors—who reflect a host of varied theoretical leanings. Exceptions can certainly be found, but if examined across disciplines, those differences appear to hold up quite well.

What then are the operational specifics that seem to cut across these two alliance perspectives in supervision? And how might those specifics be captured in a succinct but meaningful way? Based on my reading of the Fleming/Benedek and Bordin visions, some core features (after Rogers, 1957) that appear requisite for early alliance formation in supervision might best be formulated as follows:

1. Supervisor and supervisee are in psychoeducational contact (i.e., they are bound together by a matter of educational and psychological importance).
2. The supervisee, being in a state of educational incongruence, experiences both (a) vulnerability and anxiety about the process of learning psychotherapy and (b) openness and readiness to engage in that process with the supervisor. Educational incongruence can be defined as the perceived and actual dissimilarity between what learners know (real) and what they want or need to know (ideal).
3. The supervisor, being in a state of educational congruence, experiences openness and readiness to enter into the supervisory relationship with the supervisee. Educational congruence can be defined as the perceived and actual similarity between what supervisors know (real) and what they need to know (ideal).
4. The supervisor experiences the necessary psychological conditions (e.g., liking supervision, empathic attunement) and performs the necessary behaviors (e.g., verbal support, being fully present and available) that make alliance formation increasingly possible and communicates those conditions/behaviors to the supervisee.
5. The supervisee is receptive to and perceives the psychological conditions/behaviors offered by the supervisor.
6. The supervisee experiences the necessary psychological conditions (e.g., respect, desire to be supervised) and performs the necessary behaviors (e.g., verbal engagement) that make alliance formation increasingly possible and accordingly communicates those conditions/behaviors to the supervisor.
7. The supervisor is receptive to and perceives the psychological conditions/behaviors offered by the supervisee.
8. Supervisor and supervisee collaboratively discuss and identify possible goals for guiding the supervisory experience.
9. Supervisor and supervisee collaboratively agree upon and establish supervision goals to be achieved.
10. Supervisor and supervisee collaboratively discuss and identify possible tasks by which supervisory goals can be pursued.
11. Supervisor and supervisee collaboratively agree upon and establish tasks by which goals will be pursued.
12. Supervisor and supervisee remain open to discussing their relationship and renegotiating the supervisory contract as needed.

While not exhaustive, those 12 postulates—which are explicitly stated within or suggested by the Fleming/Benedek (1964, 1966) and Bordin

(1983) visions—paint a portrait of some essentials needed for supervision alliance formation to occur. Where compromise occurs at any point (e.g., a lack of openness or receptivity), alliance formation will be negatively affected and, in turn, can be slowed in its development and rendered less likely to occur. Approaches to considering supervision goals and tasks can conceivably be quite varied in scope, ranging from the more formalized and contractual to the relatively informal (see Alonso, 2000; Bordin, 1983; Gordan, 1996; Jacobs, David, & Meyer, 1995; Teitlebaum, 1990a). What appears most important is having a mutually clarifying discussion and reaching a mutually clarifying agreement.

The Fleming/Benedek and Bordin visions provide us with two highly similar ways by which to understand the supervision alliance and its development. Although having psychoanalytic provenance, the supervisory alliance has since been embraced as a construct of transtheoretical import (cf. Carroll, 2009, 2010; Farber, 2012; Hawkins & Shohet, 2012; Ladany, Friedlander, & Nelson, 2005; Levenson & Ladany, 2012; Reiser & Milne, 2012; Sarnat, 2012; Scaturo, 2012; Stoltenberg & McNeil, 2010; Watkins, 2012; Watkins & Milne, 2014). As now conceptualized in psychotherapy supervision, the supervision alliance has come to be viewed as the very heart and soul of the supervision endeavor itself. Extrapolating Bordin's (1979, p. 253) propostions about the therapeutic working alliance to supervision, the following statements appear to capture current thinking about the transtheoretical applicability of the supervisory alliance:

1. All approaches to psychotherapy supervision involve embedded working alliances;
2. Each supervision approach (e.g., psychoanalytic-focused versus cognitive-focused) involves its own type of alliance—possessing some unique features and characteristics that serve to differentiate and define it;
3. Supervision effectiveness appears to largely be a function of the strength of the working alliance between supervisor and supervisee; and
4. The strength of the supervisory working alliance is a function of closeness of fit between two intersecting sets of variables: (a) the inherent demands and requirements of the type of working alliance being implemented; and (b) the personal characteristics that supervisor and supervisee bring to and make manifest in the supervision situation.

WHAT HAVE WE LEARNED FROM SUPERVISION ALLIANCE RESEARCH?

Context and Method

In complementing the theoretical/practical material considered thus far, I would like to next examine the research that has been done on the supervisory alliance. The primary questions that I will address are: Across the last 20 plus years, what have we learned empirically about the supervisory alliance? What do we not know? What do we need to know? My specific focus will be on the supervisory alliance as studied in *psychological treatment supervision* (i.e., the supervision of psychotherapy or counseling)—as opposed to other forms of clinical supervision, such as occupational therapy or speech pathology, where psychological treatment is not the primary subject of concern. Psychological treatment supervision will be defined as: A "distinct professional activity" (Falender & Shafranske, 2004, p. 3) or "intervention" (Bernard & Goodyear, 2014) in which a senior professional (supervisor) serves as mentor or guide to a junior professional (supervisee) who is in the process of learning and practicing psychological treatment; its primary objective is enhancement of the supervisee's professional functioning, it involves evaluation of that professional functioning by the supervisor, and it is a hierarchical monitoring process (supervisor to supervisee) that serves a protective function for both patients and profession (Milne, 2007; Thomas, 2010).

In a broad-based review of psychoanalytic constructs in psychotherapy supervision, I (Watkins, 2010) examined the features of 17 supervisory alliance studies (along with parallel process and countertransference research) appearing up through the early part of 2010. The focus, with one study excepted, was on the individual therapy supervision relationship (as opposed to group and marital/family therapy supervision). As part of this half-century retrospective, and in order to provide a more complete picture of where alliance research stands now, I would like to build on and render the alliance portion of the earlier review current. Although the primary alliance conclusions were recently made (and will be referenced in my discussion), the alliance portion of the review could benefit from updating for two reasons: (a) several important alliance studies that merit scrutiny were not included; and (b) in the last several years supervision alliance studies have shown a considerable comparative increase. In the earlier review, studies were not included for three reasons: (a) investigations were published at or shortly before the review's close date; (b) investigations did not focus on the supervisory alliance as the primary

variable of interest; and (c) investigations were missed due to oversight. I have attempted here to cast my net as widely as possible and include all studies where the supervisory alliance was a variable of interest in any way. As with the earlier review, my focus will be on individual supervision; it remains the most prevalently-used form of supervision learning—what Bernard and Goodyear (2014) have referred to as "the cornerstone of professional development." Thus, to get the most contemporary, informed, and comprehensive picture of supervision alliance research, I subsequently consider the entirety of such studies done so far; to make that possible, I have taken material from Watkins (2010; with permission), identified missed and new research studies, and accordingly combined the two sources of research information for review purposes.

To identify those new and missed articles, four steps were taken: (a) PsycInfo, MedLine, Education Research Complete, and Google Scholar database searches were conducted using "supervisory alliance" or "supervision alliance" as the key search words; (b) reference sections of identified studies were examined to further identify other appropriate articles for inclusion that might have been missed ("ancestry approach"; Cooper, 1989); (c) supervision journals or journals that publish some supervision material were examined for any recent articles that might have appeared; and (d) recent supervision texts (e.g., Ladany & Bradley, 2010) were also examined to further find any other possible missed work. Based on those steps, a total of 24 new or missed studies was identified for inclusion, which were then combined with 16 of the earlier-identified studies (Watkins, 2010; the one study from that review on marital/family supervision [Inman, 2006] was not included here). The review time period spanned from 1/1990 through the early part of 2013. Each article was reviewed to determine: Setting/sample characteristics, measures used, procedure, analyses, findings/conclusions, and limitations/strengths. Table 1 provides a summary of those seven features for each study. Table 2 provides a more focused snapshot of study similarities across several selected variables of empirical import.

REVIEW RESULTS AND DISCUSSION

In examining the study information, the results will be considered according to the seven features identified in Table 1.

Setting/Sample Characteristics

The vast majority of investigations (34 out of 40) took place in university settings or settings where graduate students were being trained;

Table 1. STUDIES OF THE SUPERVISORY ALLIANCE, 1990-2013

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Bennett, BrintzenhofeSzoc, Mohr, & Saks (2008)	72 MSW students in their field placements (26female, 5male; 80% White; mean age=32.5 years; demographics provided for only 30 individuals, not entire sample)	Working Alliance Inventory; Supervisory Styles Inventory; Relationship Scales Questionnaire; Relationship Structures Questionnaire (RSQ)	Survey packet containing questionnaires provided to trainees for completion	Multiple regression analyses	Supervision-specific attachments found to strongly predict supervision alliance perceptions; alliance rated least favorably by highly avoidant supervisees	Ex post facto design; focus on supervisees' perspective only; self-report survey data;48% return rate
Bhat & Davis (2007)	119 supervisors (80 female, 39 male; 108 White, 10 African-American, 1 Latino; x age = 50.5 years; 90 master's degree, 21 doctoral degree, 8 other)	White Racial Identity Attitude Scale or People of Color Racial Identity Attitude Scale; Perceptions of Supervisee Racial Identity for White or Perceptions of Supervisee Racial Identity for POC; Working Alliance Inventory-Supervisor Version; demographic questionnaire	Survey packet containing questionnaires provided to all supervisors for completion	ANOVA	Racial identity status of supervisor and supervisee related to strength of supervision alliance (where identity status high for both, alliance rated more favorably; converse where identity status low for both)	Ex post facto design; self-report survey data; supervisors provided all ratings; no supervisee ratings included
Bilodeau & Lecomte (2010)	31 supervisees (26 female, 5 male, x age=31.9 years), 13 supervisors (9 female, 4 male, x age=37.5); each student received five supervision sessions	Supervisory Working Alliance Inventory-T (SWAI-T; supervisee version); Supervisory Working Alliance Inventory-S (SWAI-S; supervisor version); Internalized Shame Scale (ISS)	At study's outset, supervisees completed ISS and demographic questionnaire; supervisees again completed ISS after final supervision session; after each supervision session, supervisees and supervisors, respectively, completed SWAI-T and SWAI-S	Repeated measures ANOVAs	Supervisees rated alliance more favorably across all sessions compared to supervisors; supervisee shame-proneness had no effect on alliance ratings of either supervisee or supervisor	Only four individuals in high shame group; some supervisees shared same supervisor; one university sample; self-report survey data
Bilodeau & Lecomte (2012)	43 supervisees (36 female, 7 male, x age=30.1 years); each student received five supervision sessions	Supervisory Working Alliance Inventory-T (SWAI-T; supervisee version); Internalized Shame Scale (ISS); Session Evaluation Questionnaire (SEQ)	At study's outset, supervisees completed ISS and demographic questionnaire; supervisees again completed ISS after final supervision session; after each supervision session, supervisees completed SWAI-T and SEQ	Independent samples t tests; repeated measures analysis of covariance	Shame proneness affected supervisees' alliance ratings across five sessions; highly shame prone supervisees rated alliance more favorably after first session but not after fifth	One university sample; self-report survey data

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Bucky, Marques, Daly, Alley, & Karp (2010)	87 clinical psychology doctoral students(74 female, 13 male; 72 White, 1 African-American, 5 Latino, 5 Asian-American; 64 students 20 to 30 years in age, remainder over 30; 26, 36, 16, and 9 students, respectively, identified as being in their second, third, fourth, and fifth year (or beyond) of training	Supervisee Evaluation of Supervisor Questionnaire	Students who had completed practicum or internship the previous year filled out online questionnaire	Frequencies determined	"The results of the study support the... importance of the supervisory relationship or working alliance..."(Bucky et al., 2010, p. 159).	Ex post facto design; frequencies only; self-report survey data from supervisees only
Burke, Goodyear, & Guzzardo (1998)	10 supervisor-supervisee dyads (5 female, 5 male supervisors; 7 female, 3 male supervisees) from mental health center or counseling center settings; supervisees all pre-doctoral psychology interns	Working Alliance Inventory-Modified (WAI-M; parallel versions for supervisor and supervisee); Working Alliance Inventory-Modified Short Form (WAI-MSF; parallel versions for supervisor and supervisee); Session Evaluation Questionnaire (SEQ); outcome rating scale	Supervisor and supervisee completed their respective versions of WAI-M after first and last of ten audiotaped sessions; for sessions 2-9, supervisor and supervisee completed their respective versions of WAI-MSF and SEQ-M	ANOVA, t tests, audiotape coding	Supervisor ratings of alliance considered more stable and consistent than supervisee ratings; supervisee experience level appeared to affect alliance weakening and repair events	Still the only study to examine alliance rupture/repair events in process; multiple case study design
Chen & Bernstein (2000)[1]	1 high-alliance and 1 low-alliance dyad selected from 10 supervision dyads overall (9 White female and 1 White male supervisees in first counseling practicum; x age=36; 6 White female and 1 white male doctoral student supervisors [in supervision course], x age = 33)	Supervisory Styles Inventory; Critical Incidents Questionnaire; Supervisory Working Alliance Inventory (Trainee and Supervisor Versions); Complementarity Indices	Questionnaires completed by supervisor/ supervisee dyads prior to first supervision meetingand during the three supervision meetings held	Chi-square tests and correlational data	Higher degree of complementary interaction found in "high-rated alliance" dyad as opposed to "low-rated alliance" dyad	Relatively small sample pool Limited evidence to support validity of Complementarity Indices in supervision research Age and experience differences in high-alliance versus low-alliance dyads
Cooper & Ng (2009)	64 supervisees (61 female, 3 male; 64% White, 28% African-Americans, 3% Latino, 2% Asian-Americans, 2% American Indian, 1% other; x age =33.8 years;) completing internship in community/agency-based sites; 64 supervisors (55 female, 9 male; 86% White, 9% African-Americans, 3% Latino, 2% Asian-Americans,; x age =46.7 years;) providing supervision to supervisee sample	Trait Emotional Intelligence Questionnaire-Short Form; Working Alliance Inventory-Modified (supervisee and supervisor versions)	Questionnaires packets provided to supervisor/ supervisee dyads for completion	Hierarchical multiple regression analysis	Higher levels of emotional intelligence related to more favorable perceptions of supervisory alliance for both supervisee and supervisor, but no interaction effects found	Ex post facto design; self-report survey data; 36% and 26% response rate, respectively, for supervisees and supervisors; predominantly female convenience sample

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Culbreth & Borders (1999)	370 supervised substance abuse counselors (202 female, 122 male, 36 no response; 282 White, 65 African-American, 13others; x age = 41 years; recovery status=235 non-recovering, 123 recovering, 2 no response; 40% held graduate degree)	Supervisory Styles Inventory; Supervisor Rating Form-SV; Working Alliance Inventory (where "supervision" substituted for "counseling" in all items); Barrett-Lennard Relationship Inventory; supervision satisfaction items	Survey packet containing questionnaires provided to all substance abuse counselors for completion	Series of MANOVAs	Counselor or supervisor recovery status had no effect on supervision relationship variables; supervision alliance bond rated highly by counselors	Ex post facto design; self-report survey data; supervisee perspective only; one state survey
Davidson (2011)	184 social work students enrolled in field placement (164 female, 20 male; 142 White/Caucasian; x age=29 years; respndents evenly split between foundation and advanced year)	Working Alliance Inventory-Trainee Version; Supervisor Self-Disclosure Index	Online questionnaires completed by all participating students	Correlations; multiple regression	More frequent supervisor self-disclosures related to stronger supervisory alliance; certain types of supervisor disclosures (e.g., normalizing) most strongly associated with positive alliance ratings	Ex post facto design; self-report survey data; supervisee perspective only; 23% response rate
Deal, Bennett, Mohr, & Hwang (2011)	100 field instructors (FIs)/ supervisors: (93 female, 7 male; 70% White, 21% African-Americans, 6% Latino/Hispanic, 1% Pacific Islander, 2% biracial or other; x age =41.2 years;) 48 received training in Developmental-Relational Approach to Field Supervision, 52 did not (control group); 64 supervisees (59 female, 5 male; 80% White, 9.4% African-Americans, 3% Latino/Hispanic, 3% Asian-Americans, 5% biracial or other; x age =31.1 years) enrolled in year-long practicum with with supervisors	Time 1 supervisor assessments: demographic questionnaire, Working Alliance Inventory-Supervisor Version (WAI-SVOR), Competency-Based Evaluation (CBE); time 2 and 3 supervisor assessments WAI-SVOR and CBE; Time 1 supervisee assessments: demographic questionnaire, Relationship Scales Questionnaire (RSQ), Positive and Negative Affect Scale (PANAS), Working Alliance Inventory-Supervisee Version WAI-SVEE), Supervisee Levels Questionnaire-Revised (SLQ-R); time 2 and 3 supervisee assessments WAI-SVEE, PANAS, and SLQ-R	Supervisors receiving training completed assessments time 1 at beginning of first training session, time 2 at end of last training session, and time 3 at end of academic year; control group supervisors received mailed questionnaires at same times; supervisees also received their questionnaires at same times	Hierarchical linear modeling	Training led to more favorable perceptions of supervisory alliance on the part of supervisors but not supervisees; "approach appeared to help FIs improve the supervisory alliance from their perspective" (Deal et al., 2011, p. 722); supervisee attachment style had no moderating effect	Intervention study; randomized controlled trial; increased likelihood of Type I errors; lack of statistical power possible with some student sample results; self-report data

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Dickson, Moberly, Marshall, & Reilly (2011)	259 clinical psychology trainees (229 female, 25 male, 5 unspecified; mean age=28.6 years; 71% White British; 104 1st year trainees, 81 2nd year, 70 3rd year, 1 4th year, and 3 unspecified	Working Alliance Inventory; Measure of Parental Style; Reciprocal Attachment Questionnaire; Relationship Questionnaire	Online data collected from trainees across 28 clinical doctoral programs in Britain	MANOVAs; structural equation modeling	Trainees' ratings of supervisory working alliance related to their perceptions of supervisor attachment style; replication of Riggs & Bretz (2006)	Ex post facto design; focus on supervisee perceptions only; self-report survey data; return rate not reported
Efstation, Patton, & Kardash (1990)[1]	185 supervisors (69 female, 114 male, 2 unspecified; x age= 42 years; 122 clinical and 45 counseling psychologists, 12 other; outpatient clinics 33%, university/college counseling centers 31%; VAs 13%, psychiatric hospitals 21%); 178 supervisees (103 female, 73 male; 2 not specified; x age = 30 years)	Supervisory Working Alliance Inventory; Supervisory Style Inventory; Self-Efficacy Inventory	Questionnaire packets mailed out	Principal components factor analysis; hierarchical regression	Positive relationship found between supervisee self-efficacy expectations and perceptions of supervisory working alliance	Advanced practicum and intern-level students only
Gatmon, Jackson, Koshkarian, Martos-Perry, Molina, Patel, & Rodolfa (2001)[1]	289 predoctoral psychology interns (203 female, 86 male; 73.4% European-American, 6.6% African-American, 5.9% Asian-American, 5.2% Chicano/Latino, 8% other)	Working Alliance Inventory; Supervision Questionnaire—Revised; Cultural variables questions	Questionnaire packets distributed	Frequency and correlational analyses, ANOVAs and MANOVAs	Positive relationship found between discussions of cultural variables in supervision and supervisees' reported satisfaction with supervision and supervisory working alliance	Ex post facto design; self-report data; focused exclusively on perceptions of supervisees
Gnilka, Chang, & Dew (2012)	232 supervisees (200 female, 30 male, 2 transgender; 78% White, 11% African-American, 3% Latino, 3% Asian/Pacific Islander, 5% biracial; x age=32.8 years) participating in practicum/internship across varied settings	Demographic sheet; Working Alliance Inventory-Short Form (WAI-S); Supervisory Working Alliance Inventory-Trainee Version (SWAI-TV); Perceived Stress Scale (PSS); Coping Resources Inventory for Stress-Short Form (CRIS-SF)	Questionnaires answered via web link by supervisees	Stepwise multiple regression analyses	Supervisee stress (where rated more highly) found to negatively impact perceptions of the supervisory alliance; coping resources (where rated more highly) found to positively impact supervisory alliance perceptions	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees
Gunn & Pistole (2012)	480 supervisees (393 female, 80 male, 83% Caucasian, 3,5% African-American, 2% Asian-American; x age= 30 years; from master's and doctoral counseling and clinical programs	Demographis questionnaire; Experiences in Supervision Scale; Supervisory Working Alliance Inventory-Trainee Version; Disclosure in Supervision Scale	Questionnaires distributed to graduate students via the Web	Structural equation modeling	Higher supervisory alliance ratings and higher disclosure in supervision related to higher supervisee attachment security to supervisor	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Ladany, Brittan-Powell, & Pannu (1997)[1]	105 supervisees (81 female, 23 male; 1 unspecified; 71% White, 11% African-American, 5% Asian-American, 11% Latino, 3% other; x age = 29.9 years; clinical psychology 17%; counseling psychology/ counselor education 71%;doctoral 43%, master's 50%; university/college counseling center 38%, mental health center 22%, schools 27%)	Cultural Identity Attitude Scale; White Racial Identity Attitude Scale; Perceptions of Supervisor Racial Identity; Working Alliance Inventory-Trainee Version; Cross-Cultural Counseling Inventory—Revised	Questionnaire packets distributed to graduate training programs	Factorial MANOVA	Expected relations found between supervisees' perceptions of racial identity interaction and supervisory working alliance	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees
Ladany, Ellis, & Friedlander (1999)[1]	107 supervisees (72 female, 35 male; 86% White, 7% African-Americans, 3% Latino, 2% Asian-Americans, 3% unspecified; x age =29.9 years; clinical psychology 36%, counseling psychology/counselor education 59%; doctoral 71%, master's 29%; university/college counseling center 40%, mental health center 25%, VA 22%)	Working Alliance Inventory-Trainee Version; Self-Efficacy Inventory; Trainee Personal Reaction Scale—Revised	Questionnaire packets distributed	Multivariate multiple regression analysis	Emotional bond component of alliance significantly related to supervisee satisfaction with supervision	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees
Ladany & Friedlander (1995)[1]	123 supervisees (81 female, 42 male; 85% White, 8% African-American, 2.4% Latino, 1.6 Asian-American, 2.4% unspecified; x age = 30 years; 54% counseling psychology, 37% clinical psychology; 68% doctoral 27% masters; university/college counseling center 41%, mental health center 23%, VA 20%)	Working Alliance Inventory-Trainee Version; Role Conflict and Role Ambiguity Inventory	Questionnaire packets distributed	Multivariate multiple regression analysis	Expected relations found between supervisory working alliance and supervisees' perceptions of role conflict and role ambiguity	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees; advanced sample of supervisees
Ladany & Lehrman-Waterman (1999)[1]	105 supervisees (82 female, 23 male; 84 White, 12 African-American, 5 Hispanic, 1 unspecified; x age = 30.4 years; clinical psychology 30%, counseling psychology/ counselor education 67%)	Supervisor Self-Disclosure Questionnaire; Supervisor Self-Disclosure Index; Supervisory Styles Inventory; Working Alliance Inventory-Trainee Version	Questionnaire packets distributed	Univariate and multivariate regression analyses	Positive relationship found between supervisor self-disclosure frequency and supervisory working alliance components (goals, tasks, and bond)	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisee; used supervisee recall
Ladany, Lehrman-Waterman, Molinaro, & Wolgast (1999)[1]	151 supervisees (114 females, 36 males, 1 unspecified; 121 White, 12 African-American, 4 Latino, 1 Native American, 4 unspecified; x age = 31.5 years; clinical psychology 26%; counseling psychology 68%; 58% doctoral, 36% master's; university/ college counseling center 41%, mental health center 18%; schools 9%; prisons 4%; private practice 2%)	Supervisor Ethical Practice Questionnaire; Supervisor Ethical Behavior Scale; Working Alliance Inventory-Trainee Version; Supervisee Satisfaction Questionnaire	Questionnaire packets distributed to graduate training programs and training sites	Multivariate multiple regression analysis	Expected relations found between supervisee perceptions of supervisors' ethical behaviors and working alliance components	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Ladany, Mori, & Mehr (2013)	128 supervisees (100 females, 27 males, 1 unspecified; 109 White, 5 African-American, 8 Latino/Hispanic, 3 Asian-American/Pacific Islander, 2 other, 1 unspecified; x age = 35.4 years; doctoral programs represented 58% clinical psychology, 29% counseling psychology, 5% school psychology, 9% other)	Supervisee evaluation of supervisor form; Working Alliance Inventory/ Supervision-Short Form; Supervisory Styles Inventory; Supervisor Self-Disclosure Index; Trainee Disclosure Scale; Evaluation Process Within Supervision Inventory	Participants responded to questionnaires via web link; asked to reflect upon a "best supervisor" and a "worst supervisor" in responding	Series of multivariate analyses	Behaviors of best and worst supervisors identified; results supported supervision relationship as "foundational competency", "important influence on supervisee learning"; concluded that effective supervisors foremost work toward developing a strong supervisory alliance	Primarily ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees
Ladany, Walker, & Melincoff (2001)[1]	137 supervisors (80 female, 55 male, 1 other; 119 White, 6 African-American, 3 Latino, 1 other; x age = 45 years; clinical psychology 18%; counseling psychology/counselor education 68%; 110 doctoral, 27 master's; university/ college counseling center 33%, mental health center 15%; academic 15%)	Supervisory Styles Inventory; Working Alliance Inventory-Supervisor Version; Supervisor Self-Disclosure Inventory	Questionnaire packets mailed	Multivariate multiple regression analysis	Positive relationship found between supervisory style and working alliance components	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisors; could not determine return rate
Livni, Crowe, & Gonsalvez (2012)	37 supervisees (22 female, 7 male, 8 no response; modal age=45; 16 nurses, 5 psychologists, 1 social worker, 3 case workers, 2 addictions counselors, 10 other/unidentified); 10 supervisors (5 female, 5 male; 5 psychologists, 2 managers, 1 nurse, 2 unspecified); all participants from Area Health Service in New South Wales, Australia	Demographic questionnaire; Supervisory Working Alliance Inventory (parallel forms for supervisor and supervisee); Supervision Evaluation Questionnaire; Maslach Burnout Inventory; Intrinsic Job satisfaction Scale; Scales of Psychological Well-Being; California Psychotherapy Alliance Scale-Group-Modified	Supervisors received either individual, group, or individual/group supervision training; supervisees randomly assigned to individual or group supervision conditions; supervisees completed measures at baseline, again right before the start of their supervision (with the trained supervisors), and six months later	Repeated measures within groups design	Stronger supervisory alliance correlated with greater perceived supervision effectiveness; stronger alliance negatively related to burnout and positively related to job satisfaction and well-being in individual supervision condition	Infrequency of supervision sessions; self-report survey data; focused exclusively on perceptions of supervisees; absence of independent control group
Mena & Bailey (2007)[1]	51 supervisors (47 female, 4 male; 49 White, 1 African-American, 1 other); 80 workers (all female; 69 White, 7 African-American, 3 Hispanic, 1 other)	Supervisory Working Alliance Inventory (Supervisor and Worker Versions); Minnesota Satisfaction Questionnaire; Maslach Burnout Inventory	Questionnaire packets distributed	Hierarchical linear modeling	Positive relations between alliance rapport and workers' job satisfaction; negative relations found between alliance rapport and workers' emotional exhaustion and depersonalization	Ex post facto design; self-report survey data; one point in time sampled

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Mehr, Ladany, & Caskie (2010)	204 supervisees (172 females, 28 males, 4 unspecified; 181 White, 2 African-American, 5 Latino/Hispanic, 2 Native American/Alaskan Native, 7 Asian-American/Pacific Islander, 7 other/unspecified; x age=29.4 years; graduate programs represented 67% clinical psychology, 23% counseling psychology; practicum settings represented 28% university/college counseling center, 21% mental health center, 21% hospitals)	Demographic questionnaire; Supervisee Nondisclosure Survey; Trainee Disclosure Scale; Working Alliance Inventory/ Supervision-Short (Trainee Version); Trainee Anxiety Scale	Participants responded to questionnaires via web link	Chi-square analyses; multivariate multiple regression analysis	"…strong supervisory working alliance was related to a lower amount of trainee nondisclosure and a higher overall willingness to disclose in a single supervision session" (p. 110).	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees
Newgent, Davis, & Farley (2004)	15 doctoral students enrolled in supervision course (8 female, 7 male; 11 White, 4 non-White); each student received a certain number of individual, group, and triadic supervision of supervision sessions	Working Alliance Inventory (WAI; for measuring supervision of supervision alliance); Supervisory Styles Inventory (SSI); Supervisory Working Alliance Inventory-Supervisee Form (SWAI); Supervision of Supervision Evaluation (SSE)	Measures completed on each type of supervision received (individual, group, triadic)	ANOVAs	No significant alliance differences found between triadic and individual models or triadic and group models	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees; small sample size; supervisee exposure to individual and triadic supervision highly variable
Patton & Kivlighan (1997)[1]	75 graduate-level pre-practicum supervisees (53 female, 22 male; 64 European-American, 11 African-American; x age=27.7 years); 77 clients (59 female, 16 male; 69 European-American, 8 African-American; x age=20 years; compensated undergraduate volunteers)	Working Alliance Inventory; Supervisor Working Alliance Inventory (Supervisee Form); Vanderbilt Therapeutic Strategies Scale	"Clients" seen by beginning graduate-level students for 4 50-minute sessions; "supervisees" then seen for supervision session after each client meeting; time-limited dynamic psychotherapy the treatment focus	Hierarchical linear modeling	Positive relationship found between supervisees' perceptions of supervisory working alliance and clients' perceptions of therapeutic working alliance	Focused on self-report perceptions of supervisees and clients; "clients" were compensated undergraduate volunteers who had not actually sought treatment; videotape session data also rated
Quarto (2002)[1]	72 supervisees (78% female, 22% male; 86% White, 6% African-American, 4% Hispanic, 4% Other; x age=33.5 years; university counseling centers 28%, agencies 21%, psychology clinics 3%, other 15%); 74 supervisors (61% female, 39% male; x age=44.4 years; 73% professionals in counselor education, counseling psychology, or clinical psychology, 23% other)	Supervision Interaction Questionnaire; Supervisory Working Alliance Inventory (Trainee and Supervisor versions)	Questionnaire packets distributed	Exploratory factor analysis One-factor ANOVA	Negative relationship found between supervision conflict and supervision working alliance	Ex post facto design; self-report survey data; perceptions sampled at only one point in time

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Ramos-Sanchez, Esnil, Goodwin, Riggs, Touster, Wright, Ratanasiripuns, & Radolfa (2002)[1]	126 practicum students and interns (73% female, 27% male; 79% European-American, 21% Other; x age=30.7 years)	Relationship Questionnaire; Working Alliance Inventory; Supervisee Levels Questionnaire-Revised	Questionnaire packets distributed	Correlational, MANOVA, and qualitative analyses	Expected relations found between supervisee developmental level, negative supervisory events, and perceptions of supervisory working alliance	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisee
Renfro-Michel & Sheperis (2009)	117 graduate students (102f); even distribution of entry, prac and internship levels; variety of programs (school, counseling, rehabilitation, community, mental health)	Supervisory Working Alliance Inventory; Relationship Questionnaire; measured at mid-semester and end of semsester	Survey questionnaires completed	ANOVAs	Supervisee attachment related to alliance, with secure reporting better alliance than insecure at both mid and end of semester; supervisee development and working alliance unrelated	Ex post facto design; self-report survey data; of email sign-ups 67.3% return rate in first semester, 54% return rate in second semester of data collection
Riggs & Bretz (2006)	87 psychology interns (66female, 20male; 78% Caucasian; mean age=32.6 years; 78% clinical psychology interns, 17% counseling psychology interns, 2% school psychology interns)	Working Alliance Inventory; Measure of Parental Style; Reciprocal Attachment Questionnaire; Relationship Questionnaire	Online data collection	MANOVAs; latent variable path analysis	Perceived supervisor attachment style had most direct impact on supervision alliance; supervisees who viewed supervisor as being securely attached viewed supervisory bond and task more positively	Ex post facto design; self-report survey data; focus on supervisee perceptions only; 50% return rate
Schultz, Ososkie, Fried, Nelson, & Bardos (2002)	111 employed rehabilitation counselors in supervision (68 female, 43 male; 101 White, 5 Hispanic, 3 Native American, 2 Asian/Pacific Islander)	Demographic questionnaire; Supervisory Working Alliance Inventory-Trainee Form; Rahim Leader Power Inventory	Questionnaire packets mailed to counselor/super-visees in two western states	ANCOVA and MANCOVAs	More time spent in supervision related to stronger supervisory alliance; higher supervisor scores on Expert and Referent power bases related to stronger alliance ratings	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees
Sterner (2009)[1]	71 mental health counselors either now being supervised or having been supervised post degree (48 female, 22 male, 1 no response; 90% White, 4% Latino-American, 1% Native American; x age=51; 83% held master's degree, 17% doctoral; 39% private practice, 27% mental health agency, 16% private, nonprofit agency, 4% hospital, 14% other)	Supervisory Working Alliance Inventory-Trainee Version; Minnesota Satisfaction Questionnaire-Short Form; Occupational Stress Inventory-Revised	Survey questionnaire completed on Internet website by American Mental Health Counseling Association members (AMHCA)	Correlational analyses and canonical correlational analysis	Positively perceived supervisory working alliance related to greater work satisfaction and less work-related stress	Ex post facto design; self-report survey data; focused exclusively on perceptions of AMHCA supervisees; unclear how many "supervisees" were not actually in supervision and how long they had not been

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Sumerel & Borders (1996)	40 graduate-level counseling students (26 female, 14 male; 20 beginning and 20 advanced trainees; 37 White)	Supervisory Working Alliance Inventory-Trainee Version (SWAI-T); Impact Message Inventory IMI); Session Evaluation Questionnaire	Trainees watched either a videotape of supervisor addressing interfering supervisee personal issues or of supervisor addressing supervisee skill deficits in supervision; participants then completed three measures	Correlations; ANOVA; MANOVA	Negative relationship between Rapport (SWAI-T) and Dominance (IMI)	Analogue study; ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees
Walker, Ladany, & Pate-Carolan (2007)[1]	111 female graduate student supervisees (91 White, 9 African-American, 4 Asian, 3 biracial, 3 Latina, 1 other; x age=31 years; 18% clinical psychology, 70% counseling psychology; university/ college counseling centers 58%, mental health centers 18%, schools 6%; VAs 5%; state hospitals 5%)	Gender-Related Events Survey; Working Alliance Inventory-Trainee Version; Trainee Disclosure Scale	Questionnaire packets distributed	Multivariate multiple regression analyses	Supportive gender-related events found to be positively related to supervisory working alliance; converse found for non-supportive gender-related events	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees; could not determine response rate
Webb & Wheeler (1998)	96 counselors in supervision (75 females, 20 males, 1 unspecified; 44 in diploma or master's training; all registered in British Association for Counselling)	Sensitivity to disclosing in supervision assessment tool; Supervisory Working Alliance Inventory (supervisee version)	Questionnaire packets mailed to counselors for completion	Correlations and factor analysis	Positive correlation found between supervisees' ratings of alliance rapport and willingness to disclose in supervision	Ex post facto design; self-report survey data; focused exclusively on perceptions of counselor/ supervisees; 44% return rate
Wester, Vogel, & Archer (2004)[1]	103 male psychology interns (93 White, 9 Hispanic, 1 African-American; x age=33.3; 64 doctoral students 35 master's)	Gender Role Conflict Scale; Supervisory Working Alliance Inventory-Trainee Version; Counseling Self-Estimate Inventory	Questionnaire packets distributed	t tests ANOVAs	Male supervisees working with male as opposed to female supervisors perceived supervisory working alliance less favorably, lending initial support to possible male socialization explanation	Ex post facto design; self-report survey data; focused exclusively on perceptions of supervisees
White & Queener (2003)	67 supervision dyads: Supervisees–56female, 11male; 59 master's students, 8 doctoral students; 80% first year of training through internship; Supervisors–47female, 20male; 55 licensed professionals, 12 doctoral students	Supervisory Working Alliance Inventory; Adult Attachments Scale; Social Provisions Scale	Supervisees and supervisors completed survey packet containing questionnaires	Simultaneous regression analyses	Supervisors' ability to form close, healthy relationships predictive of supervisees' and supervisors' perceptions supervisory working alliance; weaker relational ability and unfavorable alliance perceptions related and vice versa	Ex post facto design; self-report survey data; 50% return rate

Table 1. (CONTINUED)

Study	Sample Characteristics	Measures/Assessment Used	Procedure	Analyses Used	Findings	Limitations
Williams, Helm, & Clemens (2012)	131 mental health therapists employed full time in community mental health agencies (83 female, 48 male; 106 White, 19 Hispanic, 1 Native American, 2 multiethnic, 3 other; 50 social workers, 11 marriage and family therapists, 40 professional counselors; 7 psychologists, 17 unlicensed professionals); received at least one hour of supervision per month	Childhood Trauma Questionnaire; Five Factor Wellness Inventory-Form A; Supervisory Working Alliance Inventory-Supervisee Form; Job Satisfaction Survey; Quantitative Workload Inventory; Trauma and Attachment Belief Scale	Questionnaires administered (in random order) to participants' at their work sites	Path analysis	Anticipated partial mediating effect of supervisory alliance on vicarious traumatization not significant	Ex post facto design; self-report survey data; limited range of scores on alliance measure may have negatively affected results; very limited amount of supervision upon which to base alliance ratings

Note: ANOVA = analysis of variance; MANOVA = multivariate analysis of variance; ANCOVA = analysis of covariance; MANCOVA = multivariate analysis of covariance.

[1]Reprinted and adapted with permission of the Association for the Advancement of Psychotherapy. Watkins (2010), Psychoanalytic constructs in psychotherapy supervision. *American Journal of Psychotherapy, 64,* 393-416.

Table 2. SELECTED FEATURES OF SUPERVISORY ALLIANCE STUDIES, 1990-2013

Author(s)	Ex Post Facto, Cross-Sectional	Self-Report Survey Data	Supervisee Perspective	Supervisor Perspective	Other Study Features/Comments
Bennett et al. (2008)	X	X	X	–	
Bhat & Davis (2007)	X	X	–	X	
Bilodeau & Lecomte (2010)		X	X	X	Five supervision sessions involved; self-report data gathered prior to first session and across all five sessions
Bilodeau & Lecomte (2012)		X	X	–	Five supervision sessions involved; self-report data gathered prior to first session and across all five sessions
Bucky et al. (2010)	X	X	X	–	
Burke et al. (1998)		X	X	X	Ten supervision sessions involved; self-report data gathered across all ten sessions; interaction data also coded
Chen & Bernstein (2000)		X	X	X	Three supervision sessions involved; self-report data gathered at four separate points; interaction data also coded
Cooper & Ng (2009)	X	X	X	X	
Culbreth & Borders (1999)	X	X	X	–	Workplace study
Davidson (2011)	X	X	X	–	
Deal et al. (2011)		X	X	X	Randomized controlled trial; data gathered at three separate points; strong study
Dickson et al. (2011)	X	X	X	–	
Efstation et al. (1990)	X	X	X	X	Validation study for Supervisory Working Alliance Inventory
Gatmon et al. (2001)	X	X	X	–	
Gnilka et al. (2012)	X	X	X	–	
Gunn & Pistole (2012)	X	X	X	–	
Ladany et al. (1997)	X	X	X	–	
Ladany et al. (1999)	X	X	X	–	
Ladany & Friedlander (1995)	X	X	X	–	
Ladany & Lehrman-Waterman (1999)	X	X	X	–	
Ladany, Lehrman-Waterman et al. (1999)	X	X	X	–	
Ladany et al. (2013)	X	X	X	–	Two-item qualitative questionnaire also included
Ladany et al. (2001)	X	X	–	X	
Livni et al. (2012)		X	X	X	Up to eight supervision sessions involved; data gathered at three separate points; well done workplace study
Mena & Bailey (2007)	X	X	X	X	Workplace study
Mehr et al. (2010)	X	X	X	–	
Newgent et al. (2004)	X	X	X	–	
Patton & Kivlighan (1997)		X	X	–	Four therapy and four supervision sessions involved; only study in which client perspective assessed
Quarto (2002)	X	X	X	X	
Ramos-Sanchez et al. (2002)	X	X	X	–	
Renfro-Michel & Sheperis (2009)		X	X	–	Assessments done at two separate points
Riggs & Bretz (2006)	X	X	X	–	
Schultz et al. (2002)	X	X	X	–	Workplace study
Sterner (2009)	X	X	X	–	Workplace study

Table 2. (CONTINUED)

Author(s)	Ex Post Facto, Cross-Sectional	Self-Report Survey Data	Supervisee Perspective	Supervisor Perspective	Other Study Features/Comments
Sumerel & Borders (1996)	X	X	X	–	
Walker et al. (2007)	X	X	X	–	
Webb & Wheeler (1998)	X	X	X	–	
Wester et al. (2004)	X	X	X	–	
White & Queener (2003)	X	X	X	–	
Williams et al. (2012)	X	X	X	–	Workplace study

Note. Ex Post Facto and Cross-Sectional = non-experimental, "after the fact" study where data collected at one point in time; Self-Report Survey Data = self-report questionnaires or assessment measures used; Supervisee Perspective = viewpoint of supervisee assessed; Supervisor Perspective = viewpoint of supervisor assessed; X = present or a feature of study; - = absent or not a feature of study.

master's or doctoral students from psychology, counseling, or social work programs were the subjects. Only six studies focused on supervision in the work place. While the supervisee's perspective only was assessed in most studies (28), both supervisor and supervisee perspectives were assessed in ten of the investigations. The supervisor's perspective of the alliance was the exclusive subject of interest in two studies. Across the 40 studies, 4,563 supervisees and 837 supervisors, respectively, participated. Where complete gender and race/ethnicity demographics were provided, the supervisees were 75% female and 80% White/Caucasian; the supervisors were 65% female and 85% White/Caucasian. The mean age ranged, respectively, from 28 to 51 years for supervisees (with most falling between 28 to 35 years) and 37 to 51 years for supervisors.

Measures Used

In measuring the alliance in supervision, the Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990) and supervision version of the Working Alliance Inventory (WAI)—both self-report inventories—were routinely used. The SWAI has parallel supervisee and supervisor versions. The SWAI supervisee version consists of two subscales, Rapport and Client Focus; the SWAI supervisor version consists of three subscales, Rapport, Client Focus, and Identification. The supervisee and supervisor versions of the WAI (Bahrick, 1990; Baker, 1991) each consist of three subscales: Bond, Goals, and Tasks. While not psychometrically flawless, the WAI and SWAI appear to both be generally accepted as providing adequate measure of the supervisory alliance. Of the 40 studies, 19 used some version of the WAI, 17 used the SWAI, 3 used both measures, and one used a self-designed questionnaire (Bucky, Marques, Daly, Alley, & Karp, 2010).

Procedures

In 31 of the 40 studies, a one-shot set of self-report survey questionnaires was distributed to participants either online or by mail. Four of the investigations (Deal, Bennett, Mohr, & Hwang, 2011; Livni, Crowe, & Gonsalvez, 2012; Newgent, Davis, & Farley, 2004; Renfro-Michel, & Sheperis, 2009) involved the completion of the same set of self-report survey questionnaires at three points in time, usually over the course of one or two semesters. Only five of the investigations were supervision process studies (Bilodeau & Lecomte, 2010, 2012; Burke, Goodyear, & Guzzardo, 1998; Chen & Bernstein, 2000; Patton & Kivlighan, 1997), where questionnaire data were collected on a session by session basis; in 3 of those 5 studies, some form of session interaction/behavior rating or coding was also employed. The number of tracked supervision sessions across investigations was 3 (Chen & Bernstein, 2000), 4 (Patton & Kivlighan, 1997), 5 (Bilodeau & Lecomte, 2010, 2012), and 10 (Burke et al., 1998).

Analyses

The analyses used ran the gamut of possibilities, ranging from the simple (e.g., determination of frequencies) to complex (e.g., path analysis, hierarchical linear modeling).

Findings/Conclusions

The findings/conclusions were largely as hypothesized and highly consistent with supervisory alliance theory. A strong or favorably rated supervisory alliance was found to be linked to such variables as: higher supervisee self-efficacy and well-being, greater willingness to self-disclose during supervision, more satisfaction with supervision, more job satisfaction, greater perceived effectiveness of supervision, more availability of coping resources, secure attachment style, more supportively-perceived gender events during supervision, an attractive, interpersonally sensitive supervisor style, higher interactional complementarity between supervisee and supervisor, higher supervisee and supervisor racial identity statuses, more discussions of culture in supervision, more favorable perceptions of supervisor ethical behaviors, greater supervisor relational ability, and more frequent yet appropriate supervisor self-disclosures. A weak or unfavorably rated supervisory alliance was found to be related to such variables as: Supervisee avoidant attachment style, higher degree of perceived stress, more exhaustion and burnout, greater amount of role conflict and role ambiguity, and more frequently perceived occurrences of negative supervision events. While some support for all measured dimensions of the supervisory alliance was found (i.e., the Bond, Goal, and Task of Working

Alliance Inventory; Rapport and Client Focus of Supervisory Working Alliance Inventory), the Bond and Rapport elements emerged most strongly and consistently across studies.

Study Limitations

As Table 2 brings into focus, the vast majority of supervisory alliance studies have been ex post facto and cross-sectional in nature. The supervisee's perspective has largely been the subject of interest, with the supervisor's perspective being tapped in less than a third of the investigations. Only one study (Deal et al., 2011) was an intervention-based randomized controlled trial. Any attention to supervision process has been virtually absent. The one study, in which alliance measurements were taken across ten supervision sessions, was published more than 15 years ago (Burke, Goodyear, & Guzzardo, 1998), with the actual data having been collected around 1990 or 1991 (Burke, 1991).

DISCUSSION

The supervisory alliance has come to be increasingly regarded as the crucial and pivotal component in the successful prosecution of the supervision relationship, considered to substantively affect and contribute to its ongoing process and eventual outcome. If we define clinical validity as the convergence of informed professional opinion over time about the significance of a particular variable for practice efficacy, then it seems the supervisory alliance now enjoys a unanimous endorsement of its clinical importance for supervisory conceptualization and conduct, and the endorsement transcends discipline lines, theoretical boundaries, and type of work setting (Brown, 2012; Dewald, 1997; DiGiuseppe, 2011; Farber, 2012; Gilbert & Evans, 2000; Goldman, 2012; Karon, 2008; Levenson, 2012; Morgan, Soetaert, & Heinrichs, 2008; Newman, 2012; Wood, 2005). The clinical usefulness and validity of the supervisory alliance for supervision do not seem to be disputed.

The vision of the supervisory alliance as tripartite in nature—involving a solid or "good enough" bond or rapport, shared goal or goals, and shared tasks between supervisor and supervisee—also appears to have gained wide acceptance. During the past 25-year period, those three elements have been increasingly presented as *sine qua non* dimensions of the supervisory relationship, and supervisors have been accordingly urged to attend to them when beginning supervision and to monitor them over the course of the relationship (Alonso, 2000; Bernard & Goodyear, 1992, 2014; Ellis, 2012; Ellis, Siembor, Swords, Morere, & Blanco, 2008; Falen-

der & Shafranske, 2004; Gilbert & Evans, 2000; Gordan, 1996; Hughes, 2012; Jacobs, David, & Meyer, 1995; Mead, 1990; Teitlebaum, 1990a; Watkins, 2013b; Williams, 1995). In addition to providing guidance, supervision goals and tasks largely derive their significance from the mutuality of the supervisor-supervisee discussion and agreement process that leads to their very establishment. In that sense, the mutuality of goal/task establishment also contributes to the building of supervisory bond or rapport.

Research across the last two decades increasingly regards the supervisory alliance as a highly robust (if not the most robust) empirical variable of substantial import within supervision scholarship (Inman & Ladany, 2008; Ladany & Inman, 2008, 2012). Yet considering the description and summary of studies provided in Table 1 and 2, it seems reasonable to ask: How truly robust is it? More than 15 years ago, in what remains one of the most rigorous, comprehensive reviews of the supervision literature ever done, Ellis and Ladany (1997) critiqued the emerging empirical studies on the supervisory alliance; they concluded that the studies suffered from a lack of randomization, failed to address numerous threats to internal validity, and failed to control for many potentially competing, confounding extraneous variables. Some 12 years later, Bernard and Goodyear (2009) offered their own critique on what had then grown to 19 supervisory alliance investigations; they accentuated that, while the results were generally supportive, the studies were correlational in nature and that any causal inferences could not be drawn. The conclusions presented by Ellis and Ladany (1997) and Bernard and Goodyear (2009) find an echo in what is said here. While the data were generally supportive of the supervisory alliance, these studies were virtually all correlational, lacked randomization, and were subject to possible influences from a number of uncontrolled variables.

Almost all the investigations were "one-shot efforts" in which participants completed a set of questionnaires either by mail or online. In the vast majority of the research, only the supervisee's perspective was assessed; client/patient perspective was assessed in but one study; supervision in the workplace was studied minimally, and the supervisory alliance in process (or over time) also was studied minimally. These findings are consistent with those identified in the earlier review (Watkins, 2010), further accentuate the limited range that defines the investigations, and bring into focus the lack of attention given to alliance areas of eminent concern (e.g., alliance rupture and repair). The supervisory alliance may be reasonably

regarded as a robust supervision variable; however, any such view must be tempered by the features of available data and what those features indicate about the current state of knowledge. In many respects, supervisory alliance study is still in its formative stage. Our knowledge base largely remains descriptive and correlational.

The current state of supervision research has been likened to psychotherapy research in the 1950s and 1960s, where focus was on developing valid measures and demonstrating effectiveness (Milne, Leck, James, Wilson, Procter, Ramm,. . . & Weetman, 2012). As Milne et al. (2012) have indicated, "we are currently about 'half-way there', working on the 'search for scientific rigour'. . . " (p. 144). That 1950s/1960s comparison seems to capture where supervisory alliance research is in its development. Two other factors that may contribute to this developmental delay are: (a) the general lack of programmatic research in supervision; and (b) the slow output of such supervision research. Unfortunately, with few exceptions (Milne, 2009, 2014; Milne & Reiser, 2012, 2014), programmatic research in supervision is more rarity than reality; that has long been the case and very much remains so (Ellis, 2010; Ellis & Ladany, 1997). Ladany has been the only programmatic force in the supervision alliance research thus far (see Table 1); but most of his work over the past decade, Ladany, Mori, & Mehr, 2013, excepted has been in more mentoring capacity than otherwise, and having now moved into a university deanship position, it is unclear how that change might affect his continued pursuit of alliance research. As for the matter of supervision study output, it is quite limited overall, with only around ten investigations per year (Ladany & Inman, 2008). With that being the case, it is easier to understand why alliance research is at such an early phase in its development.

But if supervisory alliance research is to begin moving beyond the descriptive, correlational, single-shot study, what must be done? Some of the directions are indicated by what is lacking from these 40 studies: (a) investigation of the supervisory alliance in process, including attention to the alliance rupture and repair experience; (b) tapping multiple perspectives when measuring alliance; and (c) taking a methodologically diverse and diversified approach to alliance research.

Investigation of the Supervisory Alliance in Process

The supervisory alliance does not instantaneously occur; rather, it is a supervisor-supervisee construction that develops over time and is built through sustained interaction. Furthermore, ruptures to the supervisory alliance can be expected to occur over the course of supervision and

repairs will be needed to realign the supervisor-supervisee relationship. If we are to understand the supervisory alliance as a process construction punctuated by rupture/repair events, then effort must be made to study the very process nature of the alliance itself. Such efforts have been minimal to this point, with any study of supervison for more than but the most meager number of sessions being non-existent. It is equally surprising that, with the supervision rupture/repair phenomenon being so integral to alliance theory, virtually no study of that has yet been done. The impressive body of work conducted on alliance rupture and repair in psychotherapy research (Safran, Muran, & Proskurov, 2009) could be used to stimulate thinking about research possibilities on supervision alliance rupture/repair (cf. Safran, Muran, Stevens, & Rothman, 2008). Milne et al. (2012) have also provided direction on how utilization of the fidelity framework, adapted from health behavior change research, could make supervision research more sound and move it beyond the 1950s/1960s empirical mentality. Other useful advice on conducting sound supervision research can be found in both older and more recent publications (e.g., Ellis & Ladany, 1997; Ladany & Malouf, 2010). While information on how to improve supervision research has been with us for a long time, it does not appear to have been closely heeded across many alliance studies.

Tapping Multiple Perspectives when Measuring Alliance

With the supervisory alliance being coconstructed, it would seem best to tap into the perspectives of the two primary parties. That has not been the norm. Based on the body of research, it appears that supervisor and supervisee alliance perspectives can indeed diverge (e.g., Deal et al., 2011). But what might such divergences mean? What differences might they make in the whole of the relationship? Those are unanswered questions that merit empirical scrutiny. If the alliance is to be understood, attention must be given to the two alliance perspectives that are represented, the ways in which they converge and diverge, and why.

In addition, to gain perspective on the potential impact of the supervisory alliance, the gathering of client/patient data could also be of tremendous benefit. How might the alliance affect clients in supervised treatment? Again, this has been ignored and it merits attention (cf. Hill & Knox, 2013). Although assessing impact of supervision on client outcome is a particularly thorny issue (Bennett & Deal, 2012; Lambert & Ogles, 1997), it remains a vital if not preeminent concern. As Lichtenberg (2007) has asked: How can we continue to justify psychotherapy supervision

training if we cannot empirically show supervision's effectiveness on client outcome? While we have but the most minimal data to suggest any such favorable outcome (Bambling, King, Raue, Schweitzer, & Lambert , 2006; Callahan, Almstrom, Swift, Borja, & Heath, 2009), it is clear that this type of challenging research can be done and be done well (Watkins, 2011a). But if we are to know what clients think and feel about treatment and consider the possible treatment impact of the supervisory alliance, then client data will need to be routinely gathered as a part of regular research procedure. It may be that any such supervision-outcome connections will have to be made by means of mediated or path models (Goodyear & Guzzardo, 2000; Wampold & Holloway, 1997), but for that to happen, client data will have to first become a standard component of the supervision research process.

Taking a Methodologically Diverse and Diversified Approach to Alliance Research

In reviewing these 40 studies, minimal methodological diversity was in evidence. While there are many empirical paths by which the supervisory alliance could be examined, the typical approach has been to administer a set of questionnaires to participants once. Only two studies here incorporated a case study design (Burke et al, 1998; Chen & Bernstein, 2000), one used a mixed-methods approach (Ladany et al., 2013), and one was a randomized controlled trial (Deal et al., 2011). We lack a diverse attack—quantitative, qualitative, and mixed methods—on the supervisory alliance, and if research in this area is to advance productively, the pursuit of a plurality of investigative avenues serves us best (cf. Ladany & Malouf, 2010; Milne et al., 2012). In conjunction with methodological diversity, alliance research has also lacked multi-method, multi-trait, multi-rater assessment. Research would benefit from observational data gathering and analysis. Behavioral data were coded in only three studies. Now our corpus of supervisory alliance data is based almost exclusively on self-report survey responses. While that form of information can be quite valuable, more diverse forms of data are needed if we are to build a more complete empirical picture of the supervisory alliance.

Other Factors

How might the supervisory alliance be affected by workplace considerations (e.g., particular work setting demands, type of clientele served)? For example, the "on–the-go" supervision that often occurs in medical settings can be quite different from supervision in a university psychology clinic or counseling center (cf. Morgan et al., 2008). The evaluation of

supervision and alliance impact in work sites outside the university setting is quite limited, with only six workplace studies being included in this dataset. Workplace investigations are sorely needed for our understanding of alliance to advance (see Livni, Crowe, & Gonsalvez, 2012; Williams, Helm, & Clemens, 2012). As Livni et al. (2012) have recommended:

> . . . comparing the impact of supervision and the alliance on outcomes among different groups of professionals (e.g., counselors, nurses, social workers), as well as between professionals and training students could highlight differences in important components of supervision across the field (p. 184).

Those possible differences await study and seem important to address.

Admittedly, supervision is one of "the most complex of all activities associated with the practice of psychology" (Holloway & Wolleat, 1994, p. 30). For that reason, it can be a difficult proposition to investigate: Compared to psychotherapy research, problematic effects are multiplied in supervision research by the addition to the process of a third participant (the supervisor), a second level of intervention (supervisory techniques), and the resulting, complex interactions (Russell, Crimmings, & Lent, 1984, p. 668).

As Russell et al. (1984) have indicated, creative solutions—that will no doubt typically be labor-intensive affairs—will be required for proper supervision study to be conducted (e.g., gathering data at multiple sites, extending study duration over time so that sample size can be increased). But for that to happen, coordinated, professional (or interprofessional) collaboration is a necessity. Supervision is an important, required activity across clinical, clinical health, counseling, and school psychology training, as well as social work, psychiatry, counselor education, and nursing (e.g., Buss & Gonge, 2009; MacDonald & Ellis, 2012); but as Allen Hess (2008)—clinical psychologist and seminal contributor to the supervision literature—indicated in one of the last publications before his death, "the bulk of research in supervision is the fruit of counseling psychologists and appears in counseling journals" (p. 20). Such was the case with these 40 studies and, ideally, that would *not* be so: Supervision is the property of us all and would benefit immensely from being researched as such. If supervision alliance research is to overcome some of the challenges identified here, if "problematic effects" are to be avoided and "creative solutions" found, then working together to investigate empirically this "most complex", yet supremely significant training staple would seem optimal if not requisite.

CONCLUSION

Competencies have now become the "zeitgeist of supervision discourse" (Holloway, 2012), and perhaps the most crucial competency of all lies in being able to establish and maintain an effective supervisory working alliance with supervisees. On the one hand, the supervisory alliance has come to be widely and broadly embraced as a practice variable of untold import, its clinical validity seemingly indisputable; on the other hand, however, the empirical validity of the alliance construct—while not without some foundation—tends to be somewhat limited overall and might be considered more tentative than otherwise at this time. In this review, I have described the two dominant supervisory alliance visions that continue to hold sway and critiqued the alliance research across the last 20 plus years. Compared to psychotherapy alliance research, which a decade ago was then identified as involving well over 1000 empirical findings (Orlinsky, Ronnestad, & Willutzki, 2004), the number of supervision alliance research findings pales pitifully by comparison. Let us hope that that will change.

Sue Wheeler (2007)—in an introductory editorial of a special issue on supervision—stated that the "future for research on supervision is wide open" (p. 1). I believe that her statement readily applies to where we are now with regard to the supervisory alliance. While supervision is a difficult subject to tackle, the potential impact of the supervisory alliance on the teaching and learning of psychotherapy is inestimable. It would be valuable for psychotherapy educators to know the various ways in which that potential impact occurs, the mechanisms by which the supervision alliance works, and how we as supervisors can more meaningfully and effectively contribute to making supervision a safe place and space within which supervisees can blossom and grow.

Psychotherapy supervision may well be *the* most substantial vehicle by which we teach, transmit, and perpetuate the traditions, practice, and culture of psychotherapy. The supervisory alliance is the medium by which that teaching, transmission, and perpetuation process occurs. Increasing and improving our empirical efforts is requisite if we are to: (a) have a more complete, anchored understanding of the supervisory alliance; and (b) accordingly enhance its practical application and implementation throughout the supervision process.

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"The Ickiness Factor:" Case Study of an Unconventional Psychotherapeutic Approach to Pediatric OCD

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Obsessive-compulsive disorder (OCD) is a complex condition with biological, genetic, and psychosocial causes. Traditional evidence-based treatments include cognitive-behavioural therapy, either alone or in combination with serotonin-specific reuptake inhibitors (SSRI's), other serotonergic agents, or atypical antipsychotics. These treatments, however, often do not lead to remission, and therefore, it is crucial to explore other less conventional therapeutic approaches. This paper describes a case study in which psychodynamic, narrative, existential, and metaphor therapy in combination with more conventional treatments led to a dramatic remission of severe OCD in a 12 year old hospitalized on a psychiatric inpatient unit. The paper, which is written partly in the form of a story to demonstrate on a meta-level the power of narrative, is also intended to illustrate the challenges of countertransference in the treatment of patients with severe OCD, and the ways in which a reparative therapeutic alliance can lead to unexpected and vital change.

KEYWORDS: pediatric obsessive-compulsive disorder; psychodynamic psychotherapy; cognitive-behavioural therapy; narrative therapy; countertransference.

INTRODUCTION

Obsessive-compulsive disorder (OCD) is defined for both children and adults in the DSM-IV-TR as follows: (APA, 2000, p. 462) "Either obsessions or compulsions," with obsessions consisting of recurrent and intrusive thoughts, images or impulses experienced as unwanted or distressing, and compulsions being repetitive behaviours that the person feels driven to do, usually with the aim of reducing distress. The symptoms must either

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occupy more than one hour per day or cause significant distress or social or occupational impairment. The DSM-IV-TR specifies that children do not need to recognize that the obsessions or compulsions are excessive or unreasonable, whereas adults do. Population-based studies indicate a prevalence of OCD in 2% to 4% of children and adolescents, with a mean age of onset between ages 7.5 years and 12.5 years (AACAP, 2012; Boileau, 2011). Some studies indicate that in OCD affecting children it is more common in boys (3:2), while in adults it is equally common in men and women (AACAP, 2012; Boileau, 2011). The etiology of OCD at all ages is multifactorial, involving a combination of genetic, neurobiological, neurochemical, biological, personality/trait, psychological and social factors. In some cases, infection with group A beta-hemolytic streptococcus can create a syndrome that is indistinguishable from OCD; this is part of a larger group of syndromes known as PANDAS: pediatric autoimmune neurological disorders associated with streptococci (Shulman, 2009). A full review of the etiology is beyond the scope of this paper.

In pediatric and adolescent OCD, the most common obsessions involve religion, sexuality, death or illness, contamination, and over-responsibility for feared harm to self or others or for catastrophic events (Boileau, 2011; Butwicka & Gmitrowics, 2010); the most common compulsions, meanwhile, involve cleaning and hoarding (Boileau, 2011). Some research indicates that young children with OCD have associated features of severe indecisiveness, extreme slowness, and excessive doubt about trivial matters (Boileau, 2011). There is some evidence to suggest a higher rate of comorbid obsessive-compulsive personality disorder (OCPD) traits in these children (AACAP, 2012), including a tendency toward rigidity, perfectionism, orderliness, and control. Compared to patients with adult-onset OCD, those who experience onset in childhood are more likely to have comorbid disruptive behaviour, tic disorders, mood disorders, other anxiety disorders, or attention deficit hyperactivity disorder (ADHD) (Boileau, 2011). Significant to the case featured in this article are several studies that indicate children who have OCD and comorbid major depressive disorder have greater OCD severity, and tend to have higher levels of family conflict (Boileau, 2011). Also relevant to the current case, children with comorbid disruptive behaviour disorders tend to have greater severity of symptoms, greater levels of family accommodation, more treatment resistance, and are 3.6 times more likely to be prescribed atypical antipsychotics than those without concomitant behavior dysfunction (Storch, Lewin, Geffken, Morgan, & Murphy, 2010).

Obsessive-compulsive disorder can have a significant impact on func-

tioning, both at home and at school. The 2012 American Academy of Child and Adolescent Psychiatry (AACAP) OCD treatment guidelines cites peer problems in 55% to 100% of patients, and isolation and current or future unemployment at 45% (AACAP, 2012). The World Health Organization recently stated that OCD (regardless of age group) is the tenth leading cause of disability worldwide (Gilbert & Maalouf, 2008). In addition, OCD in childhood tends to be chronic, with 41% to 60% of children remaining symptomatic into adulthood (Boileau, 2011). Predictors of chronicity include the presence of other psychiatric comorbidities and poor initial treatment response (AACAP, 2012), and also possibly the need for hospitalization (Boileau, 2011). The most commonly studied treatment modalities include cognitive-behavioural therapy (CBT), medication management (primarily with serotonin-specific reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), and atypical antipsychotic augmentation), or combined medication and CBT.

However, CBT, medication, or combinations therein often do not result in full remission (Boileau, 2011; Leib, 2001). Given this, and the high side-effect burden of the medications used to treat OCD, it is crucial that we continue to explore the potential of broader and more integrated treatments for children as well as adults. The vast majority of contemporary evidence-based research on psychotherapy in children and adolescents with OCD involves cognitive-behavioural therapy exclusively (In-Albon & Schneider, 2007; McGehee, 2005; Storch, Mariaskin, & Murphy, 2009), and the majority of nonbiological theories about the etiology of OCD, such as learning theory, are related to the cognitive-behavioural model (Kempke & Luyton, 2007). Of great concern is that many CBT experts bluntly dismiss psychodynamic theory with regards to OCD, and state that psychoanalytic techniques have no place in its treatment (Foa, 2010; British Psychological Society/NICE, 2006). Furthermore, there is disappointingly little contemporary published research on psychoanalytic approaches to pediatric and adolescent OCD (Cohen, 2011), although authors allude to the fact that therapists use these approaches quite commonly in this population (Fonagy, 1999; Quinn, 2010). Some authors argue that there is significant overlap between cognitive-behavioural and psychodynamic theories of OCD, and that the techniques, at least for adults, can be merged successfully in treatment (Kempke & Luyten, 2007).

My intention in this paper is to add support to the evidence base for the integration of psychodynamic and other therapeutic modalities in the contemporary treatment of children, adolescents, and even adults, with OCD. In a society that increasingly favours short-term and psychophar-

macological treatment strategies, the richness that these other modalities contribute to treatment may well be lost; furthermore, adolescents like the one described in this paper may all too often be deemed treatment refractory and may be heavily medicated or institutionalized when CBT and first-line medications do not lead to remission. The case study described in this paper illustrates the ways in which psychodynamic, narrative, existential, and metaphor therapy enhance the use of CBT and medication management. It also demonstrates the necessity of complex interventions in the case of an illness as multifaceted as OCD, and the indisputable fact that even young children and adolescents can struggle with sophisticated psychodynamic conflicts. The paper begins with a summary of the patient's history, followed by a description of the use of conventional therapies. Following this is a discussion of key aspects of different theoretical frameworks, and the ways in which incorporating these frameworks enriched and enhanced the clinical outcome in this particular case. I will argue that had we not employed psychodynamic and other approaches, this patient would likely not have engaged in CBT at all, nor would she have achieved such a meaningful recovery.

INTRODUCTION TO THE CASE

I will refer to the patient as "Cassandra," the name of the fictional character she created during the narrative component of psychotherapy. Cassandra was a 12-year-old in middle school, living in a suburban house with her two parents and one younger sister. Her parents, European in origin, described a generally happy marriage, and were supportive and loving. They were financially stable, with extended family living nearby. Her father worked, and her mother was a homemaker. Although there was no family history of OCD, Cassandra had a paternal grandmother with severe major depressive disorder who had attempted suicide and survived. Cassandra's medical history was unremarkable, except for pneumonia at age 10 years. She had recently begun menstruating, with regular cycles. She had no known history of streptococcal infection. She also had no history of tics, ADHD, or other diagnosed psychiatric or medical comorbidities. Although she did not meet criteria for a disruptive behaviour disorder, she was described by her parents at baseline as quite "oppositional," controlling, and perfectionistic.

Cassandra developed OCD six months prior to her hospital admission, when the family had moved to her maternal grandmother's house while their own home was renovated. Her first symptoms included prolonged and repetitive ordering and re-ordering of shoes by the front door, refusal

to empty her backpack or to discard numerous useless items, such as store tags and shopping bags, and a gradual decreasing attention to her own hygiene. Furthermore, she had become increasingly angry with her grandmother, with whom she eventually refused to associate altogether. She developed contamination obsessions and compulsions about her grandmother, and began also to avoid food, clothing, toys, furniture, and other items that her grandmother may have touched. She began to refuse any food that was even remotely associated with her grandmother, and then with her other family members, and her parents had to take her out to restaurants or buy prepackaged food in her presence, in order to get her to eat. She began losing weight. She developed elaborate rituals around the staircase at home, taking up to two hours to get up the stairs, and completing a number of rituals on each step. If her parents so much as moved or breathed audibly during her ascent, she would have to start again at the beginning. Her parents and sister, uncertain of how to cope with this, accommodated and tried to be as quiet as possible during the staircase rituals; each time they accommodated further, however, Cassandra's symptoms worsened. She developed compulsions in the car as well, requiring that the radio be on at all times and that the windows remain open even in mid-winter. She was afraid to inhale the car air, which she believed was tainted by her parents' association with her grandmother. She became increasingly (and constantly) distressed and her hygiene deteriorated further, as she refused to shower or change her clothes. She became unable to hide her rituals from her friends, and she was eventually unable to attend school.

By the mid-winter, her illness was so severe her parents brought her to a community hospital, and though she had a three-week admission, she did not receive any specific treatment for OCD. The inpatient psychiatrist suggested aripiprazole, but Cassandra and her parents refused because they were concerned about side effects. Following the admission, Cassandra saw a psychologist for three CBT sessions, but the therapeutic alliance was quite poor. Within the next month, Cassandra further deteriorated, and began refusing to enter the front door of her house. On a particularly cold night, she was unable to enter the house at all, and resisted her parents' desperate attempts to carry her in, until she urinated in her clothes on the doorstep. Once in the house she begged her mother to kill her with a kitchen knife; her parents managed to force her into the car, and drove her to a downtown hospital. On the way there, Cassandra attempted to exit the moving car on a busy street, and her parents restrained her. She was assessed in the emergency room and then rerouted to our community

hospital, where we admitted her to our child and adolescent inpatient unit. Of note is that during the initial interview, Cassandra and her parents denied any significant history of other anxiety disorders, depression, or other psychiatric comorbidities; however, given that she presented with suicidal ideation and a history of social withdrawal, irritability, mood lability, anhedonia, weight loss and insomnia, we suspected that she was suffering from a major depressive episode of several months' duration. On initial presentation, she was very thin, pale, and significantly malodourous, and she appeared older than her stated age. She was furious with her parents and highly guarded, hostile, and reluctant to engage on interview, often refusing to speak. When she did speak, everyone was struck by her adult vocabulary, her tenacious and complex arguments, and her lack of warmth.

Stabilization, Treatment Structure, and Medication Management

Our primary goal was to ensure that Cassandra was medically stable. A physical exam, a full blood-work panel, titres for streptococcal antigens, and a CT head scan were all normal. Fortunately, Cassandra ate well because the food we provided had not come into contact with her family. As per the AACAP OCD treatment guidelines, we proposed a combination of medication management and CBT. Cassandra adamantly refused medication and became hostile toward my supervisor for insisting upon it. She was willing to begin CBT, however, and so we began CBT prior to the initiation of an SSRI. She was well-versed on the side effects and risks of the different medications, and argued her case with the manner and understanding of a much older adolescent. There were many painfully lengthy negotiations with her, regarding the type of medication (SSRI versus atypical antipsychotic), dosing, and dosage form (liquid versus capsule versus pill), all of which she refused. My supervisor believed Cassandra was incapable of making decisions with respect to treatment, and as per provincial law for adolescents age 12 and older, Cassandra was allowed to contest this finding with the help of a lawyer. At this point my supervisor and I discussed which of us would be involved in the legal review board hearing, as thus far Cassandra had clearly employed the defense mechanism of splitting, such that my supervisor was "all bad" and I was "all good." My supervisor proposed that we use the splitting to our advantage, and she advocated for a finding of incapacity during the review board, whereas I was completely uninvolved in the hearing and continued treating Cassandra with daily CBT. Cassandra was found incapable with respect to antidepressant but not antipsychotic treatment, and therefore

we ordered fluoxetine, beginning at 10 mg daily. Only when we had security officers accompany us to unit with the threat of holding her down while we inserted a nasogastric tube did Cassandra agree to swallow the fluoxetine. Security officers were required to be present for the first few days. Over several weeks the dosage was titrated upward to 30 mg daily. Cassandra's mood gradually improved, as did her self-care, appetite, and willingness to attend to hygiene, and she began coming to the nursing station to request her medication, saying she felt it was helping. She denied any side effects. The psychotherapies described below occurred in parallel with the medication management.

As Cassandra herself often pointed out, she was a "complicated person" with a complicated illness, whose treatment was, in parallel, complicated. Although I will describe different aspects of her treatment under separate headings, it is important to note that these facets of treatment occurred simultaneously.

Psychotherapy for OCD: CBT Component

Although this paper intends to demonstrate the importance of an eclectic and unconventional approach to OCD, we will still begin with a discussion of CBT and the ways in which it was applied to Cassandra, because CBT was a constant part of her treatment. I would like to emphasise that many of the gains Cassandra made in CBT occurred after interventions that were more psychodynamic in nature, and this will be made apparent below. Numerous sources suggest that the effects of CBT are longer-lasting than those of medication alone (Jenike, 2004; Storch et al., 2007). Cognitive-behavioural therapy is the first-line treatment in children or adolescents with mild to moderate OCD, whereas combined CBT and medication is recommended for those with moderate to severe OCD, or for those with poor insight or cognitive deficits that would interfere with CBT (AACAP). A review of the National Institute for Mental Health data on CBT for OCD describes several meta-analyses that clearly support the use of CBT in children and adolescents (Munoz-Solomando, Kendall, & Whittington, 2008). The most effective form of CBT for OCD is known as exposure and response prevention (ERP) (Foa, 2010; Jenike, 2004), which involves gradual and systematic exposures, along a hierarchy of increasing subjective units of distress (SUDS), to the feared objects or situations. The patient's usual response (compulsion, ritual, or avoidance) is prevented during exposures. Each exposure must be continued until the SUDS score drops by 50% to facilitate habituation, so that anxiety-provoking stimuli are eventually perceived as neutral.

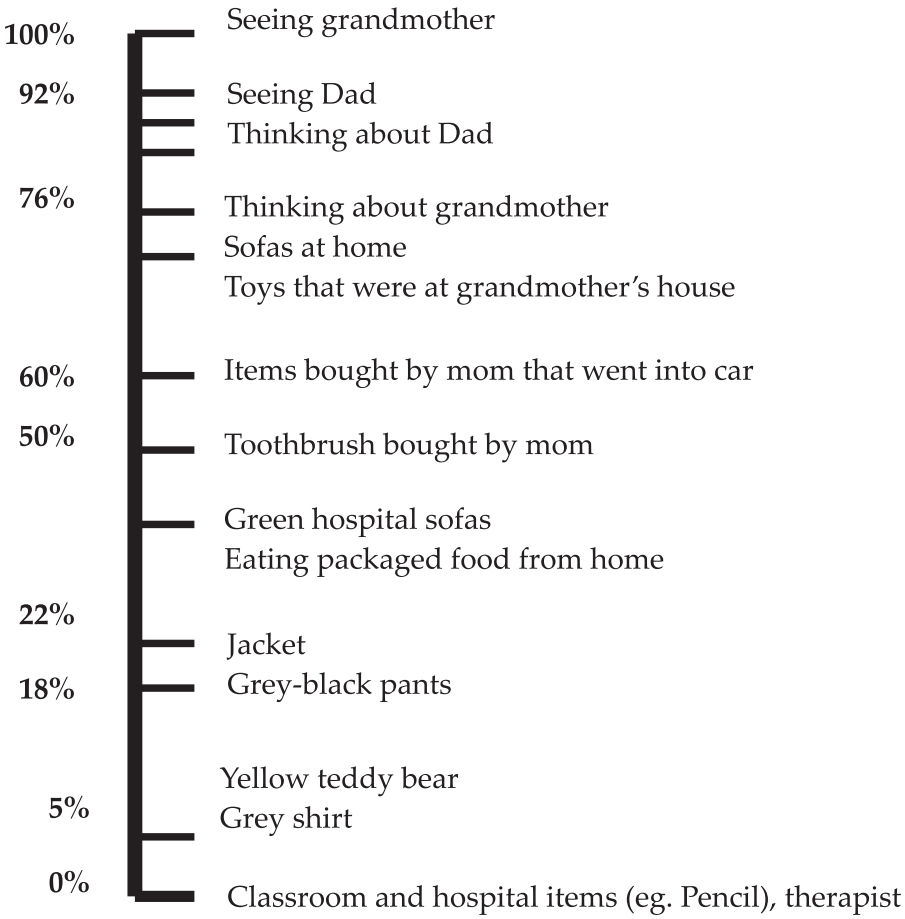
Often relaxation techniques are taught in conjunction with ERP. Exposure and response prevention is primarily a behavioural therapy, but can be combined with CBT when there is a significant cognitive component to the OCD, so that distorted thoughts are targeted along with maladaptive behaviours. There is also some evidence that intensive inpatient CBT involving 15 90-minute sessions spread over three weeks and including a family component, may confer a shorter time to treatment response than once-weekly outpatient CBT in children and adolescents (Storch et al., 2007).

The Ickiness Hierarchy

We began CBT with Cassandra by providing psychoeducation about the etiology, diagnosis, and treatment of OCD, and about the process of CBT. Given Cassandra's frustration at being referred to as "only a 12-year-old" by many adults, when she clearly was unusually intelligent, I felt it crucial to deliver this psychoeducation in adult terms. She was receptive and easily able to develop a sophisticated understanding of her disorder. She was also able to understand the concept of negative reinforcement as it applied to her OCD: namely, that when avoiding a "contaminated" object or place, she would feel relief, which would then perpetuate avoidant behaviours. She began to understand how her family's accommodation to her rituals had contributed to her deterioration. We then developed an "ickiness" hierarchy, which was to be the first of many. A brief note on the term "icky:" Cassandra and I brainstormed to describe her feelings associated with contamination, and she felt "icky" was the most fitting. Other words and terms included "disgusting," "repulsive," "worse-than-gross," and "slippery green slime and slugs, and snails, all over everything." Cassandra greatly enjoyed the process of creating hierarchies, and especially the process of rating "ickiness" scores for SUDS; she had a quirky sense of humour, and would often rate extremely specific scores, such as 92.56%, on the hierarchies. Please see *Figure 1* for an example of her first hierarchy. In the end we developed three hierarchies: one for general "ickiness," one for "repulsiveness" associated with her family, and another for her home and car. The angrier Cassandra was at a person, the higher up that individual appeared on her hierarchies. Although we expected her grandmother to be ranked at 100%, her father was, in fact, equally distressing to her.

The first exposure involved Cassandra's grey shirt, which had been brought from home after undergoing five rounds in the laundry, but which was associated with her grandmother. Cassandra wanted to do this expo-

Figure 1.
"ICKINESS" HIERARCHY



sure alone, and so after rating her SUDS score, I left her, with an expression on her face that demonstrated her aversion to the "icky" item, in her hospital room with the shirt on her lap. By the time I had returned 20 minutes later, Cassandra's SUDS score had dropped significantly. We worked with this shirt for two days, and then progressed to exposure to her yellow teddy bear, and treatment proceeded stepwise up the hierarchy for weeks. On the days I was not there, the nursing staff conducted exposures with her, though she often refused to cooperate, side-stepped the exposures, or added an unexpected complication. One such complication was that at times Cassandra's SUDS score would drop dramatically within seconds, and none of us understood whether or not she was being

truthful. In the hopes of improving consistency in exposure exercises across staff members, the unit psychologist provided the team with an educational session about OCD and the use of ERP, which proved to be quite useful. The unusual nature of Cassandra's response patterns to certain exposures may have been attributable to some of the psychodynamic factors described below.

As we progressed up the hierarchies, some creativity was required. After Cassandra began to look at photographs of her family, then of her father, we wanted to start preparing her to return home. She had not been home at this point for nearly three months. Given that the house and car were near the top of her "icky" hierarchy, we decided on a car visit, and then home visit. The goal of this exposure was to arrive in her driveway, with the idea that we would conduct a second visit in which she would then exit the car and hopefully enter the house. During the 40-minute drive, I sat with Cassandra in the back seat and we conducted extensive car-related ERP. Upon arrival in the driveway to her home, she refused to look out the car windows at her mother and sister who were waiting for her. Her mother and sister went into the house, and Cassandra eventually opened the car door and gingerly placed her foot on the ground. Suddenly, as per her usual unpredictable nature, Cassandra jumped out of the car and ran onto the lawn. Without hesitation she continued through the front door and into the kitchen, where she proceeded to open the refrigerator and drink juice. She climbed up the stairs to her room, again unhesitatingly. It was a very powerful moment for her mother, who tearfully watched from the kitchen. We were all surprised that Cassandra had not ritualized at all in the doorway, on the stairs, or elsewhere. When it was time to return to the hospital, Cassandra was actually reluctant to leave.

On her first pass home, she asked to stay overnight. I later discovered the reason for this stemmed from my challenging her by saying "I don't believe you," when she had told me that spending time at home would be easy. Following this overnight stay, she progressed to a few weekend passes, after which she was ready to be discharged. Ironically, she resisted discharge, but the timing of her discharge with the end of my rotation at the hospital provided her with an incentive to follow through, which she did. I conducted a telephone interview two months later, and for the first time in our work together, she sounded (as best I can describe) like a "normal" 12-year-old. No more sophisticated arguments or existential turmoil; instead she told me about her plans for the day, her schoolwork, a recent donation she had made, and some extracurricular activities.

In her last few weeks of treatment, Cassandra confessed to an obsession

that she had kept secret all along. After one of our discussions about mortality, she told me: "If I don't pay attention to the sun setting, it won't rise the next morning." She and I grappled with the gravity of this idea, and the immense weight of responsibility on her shoulders; indeed, no one would survive, if Cassandra did not pay attention to the sun setting! After considering this belief very seriously, I paused, and said rather lightly, "But that's not logical," and she agreed. After this, her insomnia slowly resolved, and when I followed up with her about this obsession, she dismissed it, and waving her hand, playfully said: "Whatevs."

When CBT Alone Does Not Suffice: Psychodynamic Component

Although Cassandra's progress with CBT was remarkable, it would not have been possible without the other integrated components of treatment. Following a summary of key psychoanalytic theories about OCD, I will describe some crucial turning points in the therapy that were clearly attributable to psychodynamic and other interventions.

Numerous psychodynamic theories exist about the etiology of OCD, ranging from Freud's hypothesis that the symptoms constitute a defense against unacceptable aggressive or sexual drives or fantasies (Freud, 1909; Freud, 1966; Gabbard, 2005; Moritz, Kempke, Luyten, Randjbar, & Jelinek, 2011; Sadock, 2007), to later theories about complex family dynamics, developmental trauma (Gabbard, 2005), and maladaptive attachment styles (Doron et al., 2012). The defense mechanisms found most commonly in OCD include denial, indecision, regression, magical thinking, intellectualization, rationalization, isolation, reaction formation, repression, and undoing (Chlebowski & Gregory, 2009; Freud, 1966). Some theorize that in OCD a particularly severe superego, in combination with strong aggressive impulses, results in extreme repression of the impulses (Freud, 1966) that are channeled into obsessions and compulsive symptoms (Kempke & Luyten, 2007). Anna Freud (1966) also posited that in OCD, the ego matures faster than the drives, and that the ego and superego are too advanced at too early a stage, such that they cannot adapt to the drives in a healthy way. This theory may well apply to Cassandra, given her unusual intelligence and the early development of her verbal, moral, and analytical skills. Other psychodynamic factors discussed in the literature on pediatric and adult OCD include: hyperresponsibility, control, shame, loss, relational discord (Gabbard, 2005), anger, and disgust (Allen, Abbott, & Rapee, 2006; Radomsky, Ashbaugh, & Gelfand, 2007). In his famous case of the *Rat Man*, Freud (1909) hypothesized that the fears in obsessional neurosis correspond to repressed unacceptable wishes,

and that obsessional patients intellectualize as a means of consciously accounting for unconscious processes, such as the coexistence of intense love and hate toward the same individual. Interestingly, and highly pertinent to the case of Cassandra, Freud also pointed out that patients with severe obsessions cannot be treated in a simplistic manner.

Further evidence of the role psychodynamic factors play in OCD appears in the form of case reports: Chlebowski and Gregory (2009) describe a series of adult cases in which certain psychodynamic interpretations, mainly about displacement of affect, led to a significant reduction in obsessions and compulsions. McGehee (2005) illustrates the successful purely psychoanalytic treatment of a ten-year-old boy with OCD: in four sessions per week, over the span of two years, an intensive focus on transference allowed the patient to work through numerous obsessional symptoms and achieve long-lasting remission. The author passionately argues for the reintroduction of psychoanalytic thought into contemporary treatment of OCD. Dr. Peter Fonagy presents a compelling case study of a young man named Glen, with severe OCD (Fonagy, 1999). Glen, age 15, acted on compulsions during every waking hour, and after three years of psychoanalytic treatment, his symptoms remitted. Dr. Prudence Leib (2001) presents another fascinating case study, of a woman in her late twenties who refused to accept CBT until her therapist engaged with her in two years of psychoanalysis. Dr. Leib reports that it was only when this patient felt her distress and its origins to be adequately understood, that she was willing to consider changing her behaviours; then the CBT was highly effective, and most of her symptoms, like Glen's, remitted. (A similar process occurred with Cassandra, as described below.) The authors of a series of cases specific to childhood OCD (Ierodiakonou & Ierodiakonou-Benou, 1997) also argue that a psychoanalytic approach is often essential. Although one larger study (Maina, Rigardetto, Piat, & Borgetto, 2010) reported no additional benefit of adding brief dynamic therapy to SSRI treatment in children with OCD, this study was seriously limited, given the lack of other comparison groups, and because it did not examine the potential effects of adding brief dynamic therapy to CBT, or even to multimodal treatment.

Psychoanalysis and Cassandra

Many of Cassandra's symptoms are best viewed through a psychoanalytic lens, and it is clear that the psychodynamic components of therapy fostered crucial turning points in Cassandra's recovery. Certainly, Cassandra exemplified traits described above in the psychoanalytic literature on

patients with OCD, such as a particularly powerful superego, and prominent defense mechanisms including intellectualization, rationalization, denial, magical thinking, and isolation. Early on in treatment, Cassandra confided that she believed she was a "terrible person," which certainly corresponds to Chlebowski and Gregory's (2009) formulation that "the patient feels threatened by thoughts that he or she is bad, imperfect, unreliable, uncontrollable, or immoral, and he or she is unable to integrate these attributions into a coherent self-image" (p. 9). Cassandra provided me with numerous examples of her "terrible-ness," discussing how selfish and controlling she was at home, how she cheated when playing games with friends, and how she was mean to her sister and unaffectionate with her parents. This sense of herself as a bad person may have fuelled her attempts to be "perfect," as well as to be "right" about everything. These compensatory strategies are in keeping with the psychoanalytic theory that perfectionism in OCD may be an attempt to counter unwanted hostile impulses (Kempke & Luyten, 2007).

Cassandra and I talked at length about what it means to be a "good person." Merging this discussion with a CBT technique, I suggested that she consider behaving as she would imagine a "good person" to behave, and she generated several ideas, including reducing her time in the shower, asking her mother how she was feeling, using recycled paper, and perhaps becoming a vegetarian. During the follow-up interview months after therapy, she told me that she had donated money to a charity, remembering these discussions on the unit. Viewed through a psychoanalytic lens, Cassandra's lack of warmth, noted upon our initial evaluation, supports Freud's (1909) hypothesis that resistance in obsessional patients takes the form of indifference toward loved ones. As Cassandra relaxed into the therapy, and as her defenses lowered, she displayed an increasing range of emotions in the presence of her family and staff; on her last day working with me I was both taken aback and touched by her request for a hug goodbye.

Midway through our work together, Cassandra revealed that she was furious with her father for allowing the renovation (and resultant move) and the destruction of her trees in the back yard. She also eventually confided that she was angry with her father for being, as she saw it, emotionally unfaithful to her mother. Although the verity of these claims cannot be confirmed, one remarkable change was that she only agreed to see her father and to conduct exposures around him and the rest of her family after expressing her outrage at him. Interestingly, Cassandra's expressed hatred toward her father is congruent with Freud's theory

(1909) that in OCD there is aggression particularly directed at the father. Cassandra's intense anger toward her father, whom she also loved, resonates with the psychodynamic formulations about the difficulties obsessional patients have in tolerating ambivalent emotions toward their loved ones. Her overwhelming anger at her parents resulted in particular compulsions (such as refusing to eat or repeating two-hour long staircase rituals each time they breathed or moved audibly) that controlled and distressed them, and that severely disrupted their lives. One may conjecture that the ultimate expression of this aggression was Cassandra's plea to her mother to kill her own daughter with a kitchen knife; that said, I felt that Cassandra's suicidal wish was more likely born of a genuine sense of hopelessness about her situation.

Existential and Metaphor Therapy

The literature on existential psychotherapy and metaphor therapy for OCD in children and adolescents is sparse. Nonetheless, glimpses of these approaches to therapy in children are apparent in many of the above studies, as well as in various textbooks on psychotherapy (Luepnitz, 2002). One could argue that metaphors and existential themes are common to most therapies (Yalom, 1980), but that their use is not generally made explicit. There is one paper that examines the use of existential psychotherapy with children, focusing on issues of freedom and personal choice (Quinn, 2010). The author argues that an existential approach, which comprises working through concepts of freedom, responsibility, death, meaning and meaninglessness, and isolation, is highly relevant for children with mental illness. She points out that existential themes appear almost ubiquitously in the use of metaphor and play. She also posits that an existential therapeutic stance fosters a crucial "relatedness" between child and therapist, providing a safe space in which children can understand themselves more fully, and in which they can then come to terms with the world around them. She notes that this is especially important for children who are critical thinkers, and who are highly perceptive about existential realities, given that often adults disavow these perceptions. Cassandra certainly fit into this category. Quinn also highlights the essential role existential themes and metaphorical play have in consolidating a trusting therapeutic alliance; these factors were, again, essential in our work with Cassandra. Some theorists argue that it is in fact impossible to conduct therapy without metaphors (Barker, 1985; Siegelman, 1990), and that the use of metaphors is linked to narrative and is especially crucial to psychotherapy in children (DeSocio, 2005; Quinn, 2010). Like narrative, meta-

phors facilitate the creation of a mutual reality; furthermore, metaphors allow patients and therapists to communicate sophisticated ideas using accessible and simple language, which is invaluable when working with children.

Contemplating Existence and Metaphors with Cassandra

Woven through the CBT and dynamic therapy with Cassandra were many existential themes. She described a paralyzing fear that she was "wasting time," both in terms of wasting her childhood and of wasting her life. She worried that it was "already too late to do something important with [her] life." She also described her mother as becoming "unkempt," and had begun to worry over the past few years about her mother aging and dying, and in turn, Cassandra worried about her own mortality. Cassandra reported a fear of aging beginning when she was eight, and as her 13th birthday approached, this anxiety began to heighten. She had an intense ambivalence about attending her grandmother's 102nd birthday: she feared missing what could be her grandmother's last birthday, but also feared witnessing her grandmother's aging. After voicing her fears, she did attend and it was a success. When she had disclosed the above fears to others, she had been told not to be "silly," and that she was only 12 years old and shouldn't worry about such things; these responses had then increased her anxiety and sense of isolation. She seemed relieved to be able to discuss these fears with me, and in fact I used these existential discussions as a reward for doing her CBT homework. This was a very effective strategy.

Given Cassandra's vivid imagination, and the importance of metaphors in creating a shared reality and envisioning a different future, it only made sense to play with metaphors during therapy. One of the first metaphors we used was regarding the process of CBT itself: Cassandra likened CBT to "putting on sunglasses" in order to control what one chooses to see, or think. Another useful metaphor arose when we discussed the benefits and risks of perfectionism. Cassandra recalled the story of Icarus and told me that "if you try to be perfect, you can be burned, your wings can melt." Cassandra created several metaphors for herself, as well. She first said, "I am like Pandora's box: all the evils of the world come out, and the only good thing is a tiny little bit of hope." Also early on in the therapy, she said, "I am like the Arctic tundra: barren, freezing cold, not many can survive it." When I asked her about this metaphor again several weeks later, after we had further grappled with her sense of herself as a terrible person, she said, "In the springtime, there are rabbits and a few beautiful flowers that

grow." It was inspirational to watch her inner landscape evolve, from one rife with evils, and from a state of barrenness, to one symbolic of greenness, life, and hope. When I asked her explicitly about metaphors for hope at the end of our work together, she said the following: "Just because you can't see the sun doesn't mean it's not shining." This beautiful metaphor remains with me, and I have shared it with many subsequent patients in times of hopelessness. Watching Cassandra's metaphors change as the therapy progressed, and the mutuality of playing with the symbolism together, was an unforgettable experience.

Narrative Therapy

The literature on narrative therapy for any age group is also relatively sparse, and interestingly, better-developed in the field of nursing, rather than in general medicine or psychiatry. Narrative therapy is based on the philosophy that language reflects a social construction of reality, and that mentally ill children, adolescents, and adults hold within themselves life narratives that reinforce their painful beliefs about themselves, the world, and others (DeSocio, 2005). Weaving together a new, more understanding, and more forgiving shared narrative in psychotherapy can lead to the creation of a more positive projection of the future (Bennett, 2008). Relevant to the present case study, DeSocio (2005) points out that the upheavals of social and cognitive identity in adolescence provide a unique window of opportunity in which narrative therapy can positively influence the construction of an adolescent's life story. Bennett (2008) argues that dominant narratives imposed by parents and institutions too often leave a child feeling powerless, whereas creating her own narrative provides a sense of agency. Bennett also capitalizes on the fact that children, whose imaginations remain relatively unfettered in comparison to adults, make ideal candidates for a narrative approach.

It may be no coincidence that our patient named her protagonist Cassandra. She was fascinated by Greek mythology, in which there was a priestess by the name of Cassandra to whom Apollo bestowed the gift of foreseeing the future. When the Greek Cassandra later refused Apollo's love, he cursed her in anger, ensuring that though she would continue to see the future with stunning clarity (for example, some stories state that she warned her people against accepting the Trojan Horse), she would forevermore be disbelieved (Hamilton, 1999). Various accounts of Greek mythology depict Cassandra as unusually beautiful, charming, astute, and intelligent; nonetheless, she was doomed to be perceived as insane no matter how many times her predictions came true (Hamilton, 1999).

Since a primary goal of narrative therapy is to increase an individual's awareness of the dominant narratives influencing her life, and to challenge those, it made sense to incorporate this approach into Cassandra's therapy. Cassandra—our patient—faced a "curse" not unlike that of her Greek counterpart. As described previously, her intelligence and insight were so unusual for her age that she was more often than not disbelieved, and her family and the unit staff often disavowed many of her own theories about her illness as the fanciful notions of "just a 12-year-old." Interestingly, Cassandra was reluctant to create a narrative about herself, saying, "it's too personal." This was further impetus to create a fictional character. Therefore, I will refer to our patient as Cassandra, and her character as "C.," to avoid undue confusion.

Weaving the Narrative

With some encouragement, Cassandra began to weave C.'s story, which evolved over time as we incorporated it into most sessions. At first, C. was "a happy little girl from a happy family, who suddenly developed OCD." Soon after, C. was "an anxious girl who had a great life, until some things changed, and everything spiralled out of control." When Cassandra's defenses lowered further after a few weeks of psychotherapy, she told a very different story: Here, C. was "a 12-year-old girl who always tried to follow the rules and who wanted to be perfect at everything she did." When C. was three years old, her sister was born and "got away with" being much less rule-abiding, which made C. angry. C. always felt like a "bad person;" she felt she was selfish and unkind, and also that she had to prove she was good by exceeding everyone's expectations. In grade three, as the story went, C. was given some tests at school, and no one told her what they were for. She was identified as gifted and reluctantly moved to a new school, where she began to worry about achieving "perfectly" academically. At the end of the day, to relieve stress, she would retreat to her favourite trees in the back yard and read for hours. Then, her house underwent renovation and she had to move to her grandmother's house. No one told her that as part of the construction trees would be cut down. On a visit to the home one day she realized her trees were no longer there, and that was when she began to do other things to relieve her distress, such as organize her shoes in very specific ways, keep everything in her backpack, refuse to change her clothes, act angrily toward her family members, and refuse to talk to her grandmother. Cassandra said that C.'s mother bought a book about OCD, which C. read, and C. then began to "prove her mother right" by performing more of the rituals that the book

said children with OCD do. At first C. felt that all these behaviours were "choices," and were under her control. After some time, though, her "made-up" OCD behaviours worsened, and escalated uncontrollably.

I will highlight the major themes within this third version of the narrative, just as I did when working through it with Cassandra, as these themes illustrate her psychodynamic complexity. It was clear that Cassandra relaxed into the therapy quite markedly after we began working with narrative. She became more forthcoming and at times quite playful during this process, which is in keeping with the above case reports by Fonagy (1999) and Leib (2001). Apparent in this fictional account is, again, Cassandra's perfectionism. She experienced the very real academic pressures of a gifted program, which further amplified her prior need to exceed others' expectations. Alongside this is the theme of sibling rivalry, with Cassandra's frustration that her sister could get away with less "perfect" behaviour. Also apparent are themes of loss of control, in multiple domains: the birth of her sister, the initially unexplained educational tests leading to an identification as gifted, the move to a new school, the move to her grandmother's house against her will, the construction that led to changes within her house, and the loss of her back-yard tree refuge, among other things. Themes of anger, frustration, self-hatred, and rage kept emerging in different versions of both her fictional and autobiographical accounts. Within this third story also exists an explanation for the breadth and variety of Cassandra's OCD symptoms, which is in keeping also with Cassandra's long-standing oppositionality: if we are to believe the story, it seems that she went to great lengths to prove her mother "right" that she had OCD by adopting symptoms that the OCD book described in other children. Furthermore, this story explains the surprising ease with which Cassandra was able to relinquish certain symptoms after exposures that sometimes lasted less than a few seconds, which as above stirred significant perplexity among the team members. Here Cassandra, like her Greek counterpart, struggled with others' disbelief; through narrative, however, she was able to convey her internal reality, which increased our understanding, in turn strengthening her trust in our ability to help her. Here, then, is a powerful example of the ways in which narrative relates to psychodynamic therapy and the therapeutic alliance.

On the second-last day of our therapy and of her inpatient treatment, Cassandra told me the fourth and final version of C.'s tale. She said that C. was a "pretty average" 12-year-old who was "OK at a lot of things," but wanted to do "a lot of non-average things in her life." She was tired of being average. She ended up in hospital, and learned that she is not a

"solid person" but is instead evolving. She learned that "feelings are just feelings," and that she could control them. She learned how to be her "ideal self" by taking the best parts of herself with her and throwing the rest out.

A NOTE ON TEAM DYNAMICS AND COUNTERTRANSFERENCE

Daily inpatient psychotherapy was not a standard treatment performed on the acute inpatient unit, and it was a challenge to persuade the team we should take this approach with Cassandra. There were concerns about bed availability and the cost effectiveness of a lengthier admission, and more important, about how challenging Cassandra was as a patient. She was quite oppositional and occasionally verbally tormented the unit staff. She often defied the rules; she spent hours arguing for a particular thing and then once it was done, she argued the opposite cause. Many staff members at times threw up their hands in frustration, saying that Cassandra's OCD was all "behavioural," meaning that her symptoms were not in fact the result of anxiety. She caused a great deal of strife among team members, and emotions often ran high during team meetings. Her behaviour, and its effect on team dynamics, was consistent with the clinical literature that addresses countertransference and team conflict in the treatment of adolescents and adults with severe OCD, eating disorders, and personality disorders (Bland, Tudor, & Whitehouse, 2007; Whalley, 1994). This literature indicates high levels of miscommunication, distress, burnout, and anger on these multidisciplinary teams, as well as complex power dynamics and role-reversals among treatment providers. Suggestions for management include the following (to which we did try to adhere): frequent team meetings, debriefing, repeated clarification of treatment goals, and psychoeducation that includes having more than one team member present in each interaction to reduce splitting.

It is only fair that since I described the team's countertransference, I also describe my own. My experience with Cassandra was very different from that of most of the other team members: I looked forward to working with her each day and left most sessions with a sense of progress and accomplishment. Our interactions were almost all positive. I sometimes felt allied with Cassandra, in the sense that I felt opposed and disbelieved by the rest of the team; I experienced powerful self-doubt and a fear that I was grandiose in thinking I could help her because far more experienced clinicians felt hopeless. When I reflect upon this unusual therapeutic alliance, and the ways in which my countertransference differed from that of the others, I can imagine numerous explanations. I was, firstly, fortunate

that she developed a positive transference toward me; it was easier to be empathetic toward her, because she treated me with respect. Secondly, I can surmise that the differences were related to my identification with Cassandra in numerous domains. Lastly, as a psychiatric resident, I was an underling of sorts, and as such identified with not only Cassandra, but with other patients as well.

FOLLOW-UP INTERVIEW

During the two-month follow-up interview, I was again struck by how much like a "normal" 12 year old Cassandra sounded, and what a contrast this was to her initial presentation. As we had discussed prior to ending therapy on the unit, I was preparing a case presentation about her and she had wanted me to convey certain messages to my colleagues about how to treat patients. I will, therefore, convey these same messages here. The first thing she told me was, "Burn the textbook!" She wanted me to stress that every patient is unique, and that following a textbook approach would not have worked for her. In her words: ". . . because [the textbook] is not going to cover everything, because every person is different. . . . people should put trust in the patient occasionally." She also wanted therapists to know the following: "People are complicated and just that much more complex when they're not yet sure who they are. So don't try to figure a person out, but help them to figure out who they are." Regarding patient-hood, she said: ". . . they're not really a patient per se; it's more like we're people as well who are having some trouble. You shouldn't put a label because it's upsetting. They're a person. You should say 'person who's having trouble.'"

DISCUSSION AND CONCLUSIONS

The current case study illustrates a highly integrated and multimodal treatment, with a combination of individual and family psychoeducation, and psychotherapy including CBT, ERP, psychodynamic, existential, metaphor, and narrative therapy. Furthermore, the patient benefited because there was a team of nurses, social workers, occupational therapists, psychologists, and psychiatrists, most of whom specialized in child and adolescent psychiatry. Their unique abilities were all incorporated at various points into the treatment. I hope that this case demonstrates the importance of complexity and flexibility in the therapeutic approach, as well as the importance of openness to using different types of psychotherapy when indicated, in a highly intelligent, resistant, and troubled young patient. Furthermore, I take seriously, in this report, the patient's own

belief that the less conventional parts of treatment were "the most important stuff."

In many ways, the story of Cassandra and her treatment reads like a fairy-tale, and this fascinates me because the experience of working with her also felt quite magical. In treating her, the team as a whole shifted from a position of therapeutic nihilism to one of optimism; in parallel, Cassandra arrived in a state of suicidal despair and then left in one of hopefulness. We assessed Cassandra in a traditional way, and initially proposed a traditional treatment. We adhered to evidence-based treatment guidelines, while responding to her unique needs; however, we allowed for an unusual degree of creativity in treatment, from both a team-based and an individual therapy-based perspective. As a team, we concluded that the non-evidence-based components of the treatment were essential, and we could not imagine that this degree of profound change could have been achieved solely through medication and manualized CBT. That said it is important to recognize that as with all individual case studies, there was no control group, and so it is impossible to infer causality with complete confidence. Our conclusions are also limited because Cassandra and her family elected not to remain in treatment post-admission, and so long-term follow-up data are not available. Furthermore, it is possible that simply of being away from home, in a structured environment, would have led to remission; it is also possible that the CBT or fluoxetine would have been sufficient, or that the positive therapeutic alliance we forged was the main ingredient in her recovery.

The beauty of exploring a case in depth is that it allows for a full appreciation of a patient's uniqueness, which is not possible in large randomized controlled trials. In this case the art of storytelling provided a valuable chance to consider alternative possibilities and to examine the subtle turning-points in therapy; it allowed us, the therapists, a chance to enter the particularities of an individual's psyche, and in turn it allowed that individual to feel "seen" and understood as a person in her entirety. I am convinced that had Cassandra not felt recognized in her unique perspective on her illness, her family, and life itself, she would not have undergone this transformation.

The conclusions to this "story" are as follows: OCD is a complex and multifaceted illness, as are the patients it consumes; treatment needs to follow evidence-based guidelines while also remaining flexible and accommodating to each individual; 12-year-olds can be highly intelligent and can provide valuable insights regarding their illnesses and treatment; psychodynamic, narrative, metaphor, and existential therapy do have a role in

conjunction with CBT, in treating children and adolescents with OCD, no matter how severe the illness. Finally, I wonder whether it was my inexperience that gave me the hubris to attempt such an unconventional treatment with a patient who was deemed treatment-refractory from the start. I would posit that medical and psychotherapy trainees can offer the particular kind of inquisitiveness and creativity that come with naiveté, and it is possible that these ingredients in part led Cassandra's story to such a hopeful ending.

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Ghosts in the Nursery: The Secret Thoughts of a Sick Child's Parents

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Parents facing a child's illness is difficult, nearly unbearable. In addition to the fear for their child's wellbeing, medical tests—even the entire health care system—seems to intrude upon family life, interrupting the family routine, disrupting the ability to live a normal life, and sometimes reintroducing thoughts of unprocessed traumas from the parents' pasts. This paper will explore how a therapist can expose how deep personal secrets—rejection, disgrace, disappointment—and subsequent feelings of guilt and shame arise during these crises, propose how to work with parents, and assist parents in processing these secrets

KEYWORDS: secrets; parents; ill child; damaged child; unthinkable thoughts

INTRODUCTION

Coming to terms with a child's illness is one of the most difficult challenges a parent can face. Thoughts about the sick child arouse unbearable pain and fear. In many cases, parents feel isolated and sorely miss their old daily routine. Medical tests, doctors, and the entire health system, intrude on the family. They lose the freedom to live normal lives, and often, the freedom to think disturbing thoughts about themselves and their children. At times, such thoughts join unprocessed traumas from the parent's past and undergo a process of toxification. In these situations, such thoughts become deep personal secrets: thoughts of rejection, disgrace, disappointment and hostility toward and even hatred of the sick child. Such thoughts produce profound feelings of shame and guilt. In this article, I shall try to expose these secrets, give them legitimacy, and propose how to work with the parents and assist them in processing the secrets they carry. A clinical example of a mother struggling to cope with

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her sick child is used to illustrate the work with parental secrets of guilt, shame and hostility toward the sick child.

MOURNING AND MELANCHOLIA

According to Hagman (1995, 2001), few of the clinical constructs of psychoanalysis have been as influential as the *work of mourning*. The model of mourning as a painful process of identification, decathexis and recathexis in reaction to the loss of a loved one is the cornerstone of the contemporary western understanding of bereavement, and has been used by psychoanalysts since 1917 (Abraham, 1927; Arango, 2003; Bonwitt, 2008; Fenichel, 1945; Freud, 1917; Hagman, 1995, 2001; Pollock, 1961; Kohut, 1972; Loewald, 1980; Volkan, 1981; Meissner, 1981; Frosch, 1990; McWilliams, 1994). This model has had a significant effect on how we view "normal" or "healthy" mourning, and has been used to define when and how mourning becomes pathological (Hagman, 1995, 2001).

Mourning is understood as a complex, multidimensional, and multidetermined process, reviving prior losses and separations, and necessitating a fully differentiated psychic structure and considerable ego strength for its optimal completion. Thus, the experiences that accompany each stage of mourning are different from one parent to another. Far from a severing or decathecting of the bond with the deceased, the painful travail of mourning consists of redrawing the boundaries of a libidinal boundary that was expanded to include a relationship in sensory reality and then reconfiguring the relationship symbolically onto an inner plane, thereby simultaneously transforming and preserving the cherished dialogue within the relationship (Arango, 2003).

In a brief overview of the considerable literature on the subject of mourning three major ideas are revealed in the era beyond Freud's *Mourning and Melancholia* (1917; Arango, 2003): the transcendence of loss through meaning reconstruction (Neimeyer, 1988, 2001), continuity of self-experience (Gaines, 1997), and the internalization of relationship (Baker, 2001).

An ontogenetic review emphasizes the various factors that affect the grief process. Factors such as biological age and stage of development, availability of support, ability to express and process affect, intrapsychic structure and individual capacities for symbolization, all play key roles in determining the course and type of bereavement process. Normal adjustment, from this perspective, will vary in different sociocultural situations and different types of losses; it will be of longer or shorter duration, varying according to temperament and particular circumstance, but above

all, according to the depth and quality of the object tie, and the *significance* of the deceased to the survivor (Arango, 2003).

When we go back to *Mourning and Melancholia* (1917), we see that Freud distinguishes between normal and pathological mourning. Freud claims that melancholia is created from narcissistic expressions of anger and ambivalence toward the dead person, and these are turned inward, preventing separation from the deceased and returning to life. According to Freud, melancholia splits the ego in two—one part identifies with the dead object, and the other part attacks it. In this way, the object is kept alive and becomes itself, but the object's shadow rests on the ego. This process, which combines identification and projection, creates a melancholia that does not allow the individual, using Freud's term, "to kill the dead". If so, separation is the condition for returning to life. In cases of the loss of a child, "killing the dead" is tantamount to killing the self, especially because identification is formed between the two (Bonwitt, 2008).

In a 2002 article, Ogden explained mourning and melancholia. Using the terminology of object-relation theory, he wrote that in a denial of separateness, in the sense that "the object is me and I am the object," there is a denial of the loss (Ogden, 2002, p. 773). The conclusion he then reached was that melancholy is the disease of those suffering narcissistic injuries, especially due to the great difficulty of carrying the pain involved in accepting the death of the beloved object. According to Bonwitt (2008), grieving the death of a beloved child is essentially different from mourning the death of a parent, if only because the death of a child contradicts biological logic that parents die before children. Grief about the death of a child never ends and becomes an emotional center from which the parent's meaning of existence is derived. Therefore, Bonwitt (2008) posits that this type of mourning, even if it lasts for many years, can be seen as having pathological qualities resembling Freud's distinction between mourning and melancholia.

However, we could also say that a narcissistic unity between parent and child is created within the bereaved parents. This may be the only emotional possibility open to them for bearing the pain and preserving their living child within them, perhaps in much the same way that a mother carries her fetus in her womb. This is an existential act that has no pathological qualities but, instead, is an attempt to continue existing in a life that carries infinite pain (Bonwitt, 2008).

Klein's (1940) description of the manic defense, which characterizes the depressive position, may shed light upon the grieving process when it is infinite and intensive, as with a parent grieving a child. The manic

defense is a denial of the depressive anxiety the parent feels, and marks the beginning of depressive recognition. This defense temporarily enables the individual to overcome the depressive pain and protects the ego from the complete despair that accompanies acknowledging the reality. Winnicott (1975, p. 42) called this manic defense "the notorious holiday of depression". When this defense is in use, one can observe partial recognition of the internal and external reality (in other words, part of the reality is unknown/kept secret from the person) and denial of certain aspects of depression, emotion or content associated with the depression, it is an experience of suspended animation (Winnicott, 1975).

In this paper I will attempt to describe the manic defense channel as part of a parent's grieving process. I propose this as an additional stage or way in which a parent attempts to deal with the pain of losing a healthy child.

BEREAVEMENT FOR A HEALTHY CHILD

In introducing her article in The Psychoanalytic Review, Dr Barbara Fajardo wrote about Solnit and Stark, who, in 1961, published their now classic paper, "Mourning and the Birth of a Defective Child." In that paper, they described and theorized a range of experiences that might occur when parenting a developmentally impaired child, based on the works of Bibring, Benedek, A. Freud, and others.

The idea on which that study was based is that parents are faced with their child's imperfection at birth and during various stages of development. This is true when a healthy child is born, and even more so in the case of a sick child. Parents are bound to grieve for the ideal fantasy child. However, when the gap between the fantasy-child and the real child is too great for the parent to bear, chronic mourning may develop. Solnit and Stark (1962) introduce the notion of "chronic mourning" (p. 534) to describe the sometimes lifelong depression experienced by these parents. Within their explanatory framework of mourning (as the libidinal detachment from the lost object–the fantasized perfect child), the parents' psychic task is to decathect the lost object and then cathect the new, real child. As parents never have time to mourn without experiencing simultaneous demands from the real new child, this task may be hindered. Solnit and Stark explain that parental ambivalence is created by the simultaneous demands of decathecting the lost child and recathecting the new, real but damaged, child; because the ambivalence is often unbearable, it is repressed. The ambivalence and its repression contribute to further difficulties in completing the mourning and recathecting process. The ambiva-

lence cannot be worked through, as it can in normal mourning, because the daily encounters with the damaged child do not permit a real "losing" of the object (Fajardo, 1987).

For the parent the ambivalence that is left motionless and frozen may be transformed into an inner secret in an attempt to preserve the ego's use of the manic defense. The child's illness may reawaken the mother's identifications with her ill infant and her own mother, as well as attendant omnipotent wishes to protect her child from danger and damage and cure him if he is ill. Like the seriously sick analyst who cannot cure himself, the mother who cannot cure or protect her child feels narcissistically wounded on the one hand, and revisits infantile omnipotent fantasies of invulnerability and curative power on the other (Bemesderfer, 2000).

When she is confronted with her child's illness, the mother may be tossed between her disturbing feelings and thoughts about her child and unresolved conflicts of her past. When confronted with trauma, the secrets that have been passed between generations, from mother to daughter, cause an internal flare-up. The mother's inner secret may become multilayered, and draw into it unresolved childhood traumas and disturbing thoughts from the present struggle with the child's illness. Unraveling the secret in therapy requires work on all the different levels to gradually release the secret. At the outset, one must work on the here and now, dealing with the mourning for the damaged child and the loss of the perfect one. Then, when space has been created in the parent's external and internal reality, one can attempt to work through past conflicts that have surfaced in the wake of the child's illness. When the parent is ready to confront the loss that has been denied so far, then he or she can begin to cry for his sick child.

In crying, a person gives expression to emotions, thereby reducing the tension and the grief (Klein, 1940). Since tears are identified with secretions, they become a means for the parent to expel bad feelings and objects. When a person cries or grieves, his internal objects grieve as well. In every loss in the present individuals are confronted by previous losses they have known (Klein, 1940). The parent of a sick child cries for his child's loss of good health, as well as for the internalized objects of his childhood. In the best scenario, he recruits the objects of his past to grieve with him, because the thought of a sick child is an unbearable burden to bear alone. Yet, in contrast to the bereaved parent whose primary task is coming to terms with the loss of a child, the parent of a sick child is at the eye of the storm. He must marshal all his strength to fight for his child, and at the same time endure the dread, the pain and the unendurable emotions.

For the parent coming to terms with a child's illness includes numerous stages. One of the options proposed in this paper is that, with the initial diagnosis, the parent's reaction may be one of manic denial. To the extent that the parent is able to grasp the diagnosis, he becomes melancholic; and from that moment on, there may be an irregular swing between melancholy and manic denial (Klein, 1940). The use of the manic defense is necessary, at times, to enable the parent's ego time to recover, and to provide a safe haven from the pain and despair that accompany the depressive position where the parent acknowledges his difficult reality. The danger in this process, however, is that one may get stuck in this position and there may be an internalization of the hostility toward and hatred of the child. Sometimes this hatred relates to the parent's unprocessed feelings that are like ghosts from the past. It is hard to contemplate the hatred, the guilt and the shame that come with the thought of an ill child but a healthy parent. The fear of survival, and of being punished for it, is great. At times, the illness may exact such an enormous price from the whole family that the parent becomes exhausted and seeks relief from the fight for the child's life. There may even be moments when the parent entertains the notion of forfeiting the life of the child altogether. It such times, the parent cries not only for the child but for himself as well.

It is inconceivable, unnatural, and unthinkable that a mother should outlive her child. The illness of a child is beyond comprehension. It arouses pain, fear and a sense of dread. It is as unnatural as the situation in which a mother tends to her adult offspring. It may be said, albeit tentatively, that the thought of our own mortality—that our children will bury us sooner or later (preferably later)—is far more bearable than the opposite: that we will bury our children.

There are unthinkable thoughts (Bion, 1962) that the mind buries in an attempt to protect and spare us pain and turmoil. This paper addresses the buried secrets hidden from the thinker himself.

In a well-known Hebrew children's song, a child describes his father as a mighty hero whose ladder reaches the heavens. Who among us cannot relive the pain of discovering that daddy does not have a ladder that reaches all the way to heaven? And, in the same vein, who can deny the painful awareness that we cannot bring heaven down for our children either? And that sometimes children go to heaven without the benefit of daddy's ladder? How great is the pain of a parent wandering the halls outside his child's hospital bed?

I shall begin with a description of the secrets in our lives, making the distinction between conscious secrets (of which the possessor is aware) and

unconscious or repressed secrets. I will suggest that some secrets can be simultaneously conscious and unconscious for their possessor.

THE SECRET

1. A Conscious Secret

A conscious secret is one that is known to its possessor, and it is something that the person does not want to share with others. The Latin root of the word secret is *secretus*, meaning "to separate" or "put aside by itself." Its derivative, secretion, refers to a matter that is separated or differentiated, with the suggestion of something unclean and unnecessary that needs to be disposed. The French word *secretaire* means both "desk," a place where private (read: "separate") things might be kept, and "a secretary", a person in possession of confidential (again: "separate") information. The idea of "separation" is central to the etymology of each of these words. A secret marks the boundaries between insiders and outsiders (Landau, 2004), which is why it is so significant to the development of the self from the very earliest stages of life.

According to Landau (2004), a conscious secret is one for which the possessor can find no one with whom to share it. Buried deep below is the primary, unconscious material that has not been well assimilated. In her view, the private is conscious emotional content that lies fairly undisturbed in a closed drawer of the emotional *secretaire*. This conscious part is the exposed tip of a deep central core in which the "incommunicado element" (Winnicott, 1965, p. 186) is found: it is the essence of the soul, which is hidden quietly and privately and contains the uniqueness of the self. Winnicott claims that this basis does not, by its nature, communicate; it is unknown and has to be left undiscovered. It is agonizing only if it is penetrated or attacked (Winnicott, 1965).

2. An Unconscious Secret

Freud (1919) described the secret as unconscious, and in his thoughts about the uncanny, he made a connection between the repressed and the secret. The uncanny is at the same time familiar and homely, and secret and hidden. Its repression has turned it into something alien and forgotten, and its return is a source of dread. According to Freud, "the uncanny is the name for everything that ought to have remained hidden and secret and has become visible' (1919, p. 220). Khan (1989) spoke about the secret as a potential space. In his opinion, in situations of emotional trauma, a person may take refuge in symptoms or disappear into a secret. What is hidden within him or repressed is subject to reprocessing, but what has

disappeared into the secret is cannot be reprocessed, or, in other words, is unconscious. When the development is disrupted, however, the potential space of the secret is transformed into "secrecy" (Khan, 1989). In Khan's view, it becomes unconscious. Nevertheless, it is possible that what is made to disappear within a secret becomes hidden from the eye (to paraphrase Steiner), or impossible to contemplate, but not repressed; it is then ignored, though it is in plain sight. I suggest, therefore, that the secret can be simultaneously conscious and unconscious to its possessors.

3. A Secret Hidden From View

Steiner (1985) described situations of psychic retreat in the case of extreme anxiety. In certain situations, the patient turns a blind eye to the truth to avoid the fear surrounding an encounter with others and with reality. He has access to all the facts, but the conclusions are denied him. The retreat thus provides an area in which there is no need to confront reality, and is a place governed by fantasies of omnipotence that do not require close examination. This situation is described as one in which the patient is disconnected, distanced, and turns a blind eye. I would argue there are secrets hidden from view and detached from the possessor, but simultaneously conscious and unconscious. In other words, for a person to turn a blind eye, he would have to recognize the secrets at some level. It would then be possible to say that the person hides a secret from himself.

I suggest that some parents of sick children carry within them family secrets, unresolved conflicts of previous generations. Such secrets emerge and become unbearable in the face of the child's illness. Since the secrets are unprocessed, and their possessors are either detached from them or turn a blind eye, when the secrets burst to the surface as a result of the illness, the experience threatens the parent's sense of integrity. It is an experience that is both familiar and uncanny (Freud, 1919), since it is not the parent's first encounter with these secrets.

THE FORMATION OF THE PARENT'S EMOTIONAL SECRET

Sometimes the parent has no way of expressing the feelings aroused by the child's illness. As the violent reality causes cracks in the parent's most hidden and private place, things begin to seep outward and inward. Part of the suffering of the sick child's parent derives from the struggle of the psyche not to let the hidden things out.

When narcissistic vulnerability and the element of secrecy are more present in family life, the penetration of the parent's private place will be more violent (Faimberg, 1988). In other words, the assumption is that

those who bear traumas from the past as living memories may have a stronger manic defensive response and have difficulties moving from this defense to a depressive position of accepting reality. I propose that a parent who has disturbing, unprocessed secrets or a parent who as a child was able to sense his parents' guilt, shame, and hostility about the secrets they kept from him, will have a stronger reaction to current events and will disconnect from his feelings to the point where they become secret and hidden even from himself.

1. The Parent Meets a Harsh Reality, which Reduces His Potential Space and Makes Him Uncomfortable

Parents whose children have a serious illness lose their independence, the little moments in the day when they can be themselves and for themselves. There is no private self to which they can return and regroup. They are absent from work, outside the normality of daily life, away from sympathetic acquaintances. They become passive victims of their own lives. It is not only the body of the child that is examined, penetrated and pierced. They themselves, in green hospital robes, become invisible, or at least draw scant attention, and are invaded by questions and the intrusion of doctors and nurses. They feel themselves unbearably agitated or half-dead, with their lives on automatic pilot. Being unseen or unheard may be their only survival strategy. The fear of catastrophe, the hatred and the guilt, reduce the parents' potential space. The facility of symbolization, playfulness and optimism, so vital in such situations, is in danger of collapse, and consequently the ability to think is blocked (Benjamin, 1999; Freud, 1896).

2. The Discomfort of the Parent Triggers Inner Unprocessed Conflicts, which Are Accompanied by Guilt, Shame, Hostility and Hate

These interlaced feelings become the parent's secret by virtue of their aggressive, hate-filled and painful nature, regarding either the child or phantoms from the parent's past

Guilt and Shame

Freud distinguishes between a sense of guilt following an actual event and pathological guilt. For Freud, guilt stands alone, and is not necessarily the result of something else. In many situations, the sense of guilt is unconscious; that is to say, there is a conscious effect of guilt without an awareness of an actual event (Freud, 1906). In defense based on isolation, the sense of guilt is transposed from an actual event to some other event (Klein, 1975). Another form of unconscious guilt is connected to faith or

religious sentiment, which considers that a person is aware of the reward or punishment that attends good or bad deeds. If something bad happens, he is apparently to blame. If we think in terms of reward and punishment, the parent of a sick child might ask himself: "What have I done?" "How have I sinned to be punished in this way?" "I sinned, but it was my son (or daughter) who was punished." An unbearable thought: Do the sons bear the sins of the fathers?

For Klein (1975), the source of an unconscious sense of guilt lay in the identification of urges of hatred toward the other, expressed as feelings of inferiority. A person burdened by guilt unconsciously fears that he is unable to love or to control his violent urges. A sense of guilt, experienced as concern for another person and fear of losing that person's affection, is rooted in the infant's hatred of its mother. The identification of the infant with its mother is a genuine consideration that arouses willingness to sacrifice and a fantasy about healing the hurt. Schizo-paranoid guilt reflects a dread of death and fear of revenge; depressive guilt expresses concern for the object (Klein, 1975).

Modell (1971) proposed the concept of unconscious bookkeeping based on phylogenetic development and an evolutionary biological approach with regard to survival guilt. The assumption was that society's resources are limited. The individual understands that anything good that comes his way is at the expense of someone else. "Survivor guilt" relates not only to the victims, but also to the very continuity of life itself—to say nothing of the enjoyment and happiness that life can provide. There are cases in which psychic pain masks repressed feelings of guilt. The repression derives from a refusal to acknowledge loss and to grieve for it. In such cases it is necessary to expose the repressed guilt (Kogan, 1990). In other words, there is a need within the parent to explore the original secret guilt to which he has turned a blind eye. When that guilt is exposed, the parent will no longer need the acting out and the futile attempts at repair. He will be able to endure his thoughts about his child and about himself, thereby converting unthinkable thoughts into imaginable ones.

Solnit and Stark (1962) described the transition from caring about the ill or deceased child to narcissism, from grief to melancholy, and from feelings of guilt regarding the child to guilt regarding the self. In their opinion, a parent sometimes stops grieving for the child and is left with grief for himself, for what is lost in his internal world, and for the loss of his ideal–the idea of immortality or of undying relationships. In short, he grieves for the death of another.

The parent faced with a seriously ill child, mourns the loss of the ideal

healthy child that occupied his fantasies, the loss of the perfect family, and the loss of the ideal self. The pain is for a reality that is gone forever, for one that has been replaced with a new, flawed and ephemeral reality. It is possible that the parent's feelings of guilt toward the child's illness may be guilt toward another person, and with it the guilt about something other than the child, genuine concern arises that arouses love for the child and a preparedness to sacrifice. On the other hand, the guilt could carry a touch of narcissism that reflects dread of death and fear of revenge. Perhaps, then, it may be said that the parent cries for someone else. The parent grieves for himself and for earlier losses. He feels he must keep his narcissistic guilt a secret. The parent is ashamed and guilt-ridden, forced to guard this terrible thought, keeping it a secret from his child and perhaps from himself as well. Perhaps he has agonized over it from his own early childhood. The parent now grieves over a more distant and primal loss, over the place at which reality breaches wholeness, leaving trauma in its wake. A hateful present reality meets the hatred of an early reality and arouses the pain of primal loss.

For the parent, the encounter with the child's illness is fraught with traumas and secrets from the past, and brings him face to face with his own narcissistic vulnerability. In especially tenuous situations, the parent may find himself dissociated from the feelings of guilt and shame he has toward his child. The disturbing feelings will appear without reference to the object (the sick child, in this case), and may be transformed into a secret which the parent unconsciously rejects or with which he severs any connection. These feelings, in line with Freud's theory (1917), will seek relief through conversion into overprotectiveness of the child (great concern for the child and, simultaneously, passive-aggressive behavior toward him, or unsuccessful treatment, disturbing symbiosis, and so on), somatic expressions, or object substitution (anger at the medical staff; internalizing the anger toward the parent himself, and so on). In other words, since the disturbing emotions will not find direct expression in fantasy and deed without being distanced from the consciousness, the parent may exhibit various symptoms, such as depression or dissociation, withdrawel from friends and family, etc. It is important to help the parent make space within for processing the current loss, sometimes by resurrecting phantoms from his past to allow movement between schizo-paranoid guilt and depressive guilt.

It is important to be able to reassure the parent that his feelings of guilt and shame are normal for his abnormal situation, and to give those feelings genuine legitimization.

Hostility and Hatred

Although Winnicott (1949) had much regard for the strength of a mother's love for her baby, he also described the reasons for the mother hating her child. He grouped all the negative emotions, including the milder ones, under the title of hatred, which he juxtaposed with love as a list of equal weight. According to Winnicott, hatred that stems from unconscious identifications through counter-transference differs from hatred formed as a reaction to the child's personality or behavior, i.e. objective hatred. In his view, the mother hates her baby before the baby hates its mother. The assumption is that the greater the gap between the fantasized child and the real child, so that the mother's hatred for her real child grows.

Analytic examination indicates that disappointment, narcissistic mortification, and depression are the underlying reactions to the defective child. Thus, far from being over valued as a love object, the defective child is devalued by the mother who also devalues herself. To the extent to which an unconscious, negatively cathected self-image representation dominates the mother's feelings about herself, the damaged, ill child will serve as a confirmation and a reality basis for such feelings. Depression, a feeling which can be conscious or unconscious, has many different facets: sadness, mourning, helplessness and hopelessness, as well as a feeling of worthlessness; rage, hatred, bitterness and anger turned towards the self or outwards are some of the other aspects (Lax, 1972).

Benedek (1959) suggested that the clinically observable rage and hatred of these parents is due to regression to negative identification with a bad, frustrating mother, which is provoked by the current failures and disappointments with the defective child. According to this model, the manifest relationships and interactions with the child become symptomatic or expressive of a regression to the mother's own early conflicts. The frustrations with current parenting are symbolic of the parent's early frustrations with the bad mother; difficulties in parenting a defective child are hence, ultimately, conflict-based and become conflict-ridden. The overprotective, over-solicitous, smothering-the-child attitude and the neglectful, indifferent attitude are opposite ways mothers use to cope with the hostile and frequently murderous impulses that they harbor towards their impaired children. These attitudes reflect unconscious feelings of self-hatred, projected upon the child, which represent the unconscious negatively cathected self-image. When the mother wards off her feelings of grief by establishing a guilty, depressed attachment to the damaged child, she

may fail to adequately relate to other members of the family because she feels she must devote her life to the care of the damaged child. Conversely, the mother may identify with her defective child. In identifying with her defective offspring, the mother feels narcissistically wounded. This narcissistic injury is often intolerable because the mother feels painfully defective as she is caring for her damaged child (Solnit & Stark, 1961).

The mother's withdrawal to a secret becomes, then, denial of the child's needs, and in essence, denial of her own motherhood. In Winnicott's view (1949), a mother can endure her hatred of the child and do nothing about it. Nevertheless, when the mother has no way of expressing her hatred (being angry with the child, confronting him, and so on)—and, I may add, is unable to allow herself to think hateful thoughts about the child, afraid of what she might do to him or fearful of the interlacing of fantasy and reality—and suddenly the child about whom she had hateful thoughts was hurt or ill, the mother finds her thoughts unbearable. She fears her thoughts have created reality; the very idea is terrifying and unimaginable. Can one sympathize with such a mother, despite her hateful thoughts?

Without maternal empathy, a woman experiences alienation and incompleteness. The absence of a woman's empathy toward a child often reflects her lack of empathy toward herself, or toward the child or the infant within herself. The parents' ability to connect to their hatred, or allow themselves space to feel the hatred, is what will allow the child to identify with those feelings and to both hate and, hence, love himself. This way offers hope of therapy that is tailored to the needs of the child and free of burdensome secrets. Only then can the ghosts and unthinkable thoughts be swept out of the treatment room.

3. The Parent is Disconnected from His Feelings to the Point at Which They Become Secret and Hidden even from Himself

The parent cannot reveal his feelings of rejection, his fears and his hatred, nor can he separate from the object of his hatred. In his mind, internalizing these feelings (as introjection) and keeping them within endangers him. He imagines that externalizing these feelings (as projection) will create a sick, unbearable world. In either case, the parent struggles with an impossible situation (Britton, 1992). Trapped, the parent often distances himself from his true ego, remaining only with his dead-false and uncommunicative ego. We find traces of the struggle in symptoms that the parent develops. Some are physiological, like headaches, backache, exhaustion, insomnia, loss of appetite and memory loss. Emotional symptoms may include depression, anxiety, feelings of guilt or

shame, hostility and unspecific hatred of the child. The internal struggle, in effect, robs the parent of the connection between the symptom and the buried emotional content.

THE THERAPIST'S WORK WITH THE GRIEVING PARENT

When treating the parent, therapists need to consider the feelings of loss, hostility and hatred, guilt and shame that accompany the attempt to cope with a sick child. The specific ways in which the parent attempts to cope need to be examined in the context of the interpretation he gives to his child's illness. To this end, it is sometimes necessary to be oriented to understanding the parent's history and internal conflicts. The intention is not to offer an interpretation of the parent's past and his bad objects during the critical period of the child's illness; however, if the therapist is able to identify the main conflicts in the parent's past, it is possible to better understand his fears and unthinkable thoughts. The therapist may need to keep those thoughts within for a certain period of time, and work through them on the parent's behalf. Later, the clinician can begin a gradual processing of the secrets that surfaced at the time of the child's illness. It is important to give the parent's secrets legitimization and a sense of the normality, even if he himself does not articulate them. A comforting statement (like the following example) can help the parent begin thinking about his hateful thoughts: "There are thoughts that go through a parent's mind, but it's hard to find a place for them because they are disturbing and embarrassing. But it's important for you to know that many parents have these thoughts, and perhaps you do too . . ."

It must be taken into account that the parent's struggle has various stages, and the confrontation with his hidden thoughts should be proposed at different levels and at different junctures. At the beginning, therapy should focus on the here and now related to the critical medical treatment. This is a maintenance stage, and the clinician will need to process some of the hard things within without interpretation. In the next stage, the therapist can gradually make connections between the parent's disturbing thoughts about his child and the unprocessed disturbing thoughts from the parent's past. It is important to try and identify situations where the parent bears past traumas as living memories that have not been processed. In this situation, there may be a malignant flare-up of the trauma. It is then important to face both traumas: one must process the initial trauma, thus drawing strengths for processing the current trauma.

This is a lengthy process that extends beyond the period of the child's hospitalization. It is important for community social workers to be in touch

with the parents, and to invite them to continue therapy after the child has passed the critical stage. Another option is for the parents' social worker in the hospital ward to continue attending them for several months after the child has been discharged. Sometimes it is only at that later stage of the traumatic experience that collapse takes place, when the hard, turbulent phase of treating the child is ostensibly over, and the family is able to return to its normal routine.

Since the secrets are often multi-layered, they contain both the fears and the difficulties surrounding the illness of the child, and conflicts from the parent's past that were exposed because of the violent intrusion of the illness into his secret and private place. Sometimes, the only indication that the parent holds inner secrets is that the therapist also experiences the secret during therapy. Situations of diminished thinking on the therapist's part, blockages in therapy, a sense of two dimensionality, and the absence of therapist symbolization in the one-hour session may relate to the secret that the parent guards within. Very often, the goal of therapy is to release the blockage and restore movement without the parent's awareness.

The unconscious may be conceptualized as a web of internal and external connections, within the person and between the person and the surroundings. There is constant work of weaving, building, and expanding. In traumatic situations, though, the movement is blocked and the building of the unconscious is halted. It is then that there is a collapse in the parent's emotional space, and the retreat into the secret takes place. The question is how to restore the arrested movement in the parent's mind. Achieving this purpose requires work with the clinician's unconscious, and that in turn will reactivate the patient's unconscious. To this end, the clinician must adapt and allow his unconscious to meet that of the parent. Together they can recreate the parent's story and release the blockage of movement within the parent's mind.

The shared structuring of the significance of collapse and withdrawal into the secret, and the place where it is produced, requires that the clinician not rely on past assumptions but allow the significance to be built in the here and now between his own unconscious and that of the patient. The therapeutic track is not one of deciphering the unconscious and remembering the repressed, but of experience, of facing the horror and the madness. The therapeutic sessions will provide the missing foundation for holding the patient, and the clinician will become the womb in which the patient will be held.

In some cases, the conversion of the parent's thoughts to an inner secret can be avoided if the clinician is able to be an "environmental mother," as

Winnicott (1965) puts it, and listen to the patient's unconscious by means of his own unconscious, to dream him, and to play with him, without preconceptions and without prior knowledge. In dealing with the child's illness, the clinician too can be drawn to a place in which his perspective narrows and he becomes unknown to himself. The fears, the pain and the secrets in his past might overwhelm him and reduce his ability to think and to play with his thoughts. The return from that to a vital rhythm becomes possible only when the therapist is able to be attentive to what the patient is experiencing, to what he himself is experiencing, and to structure something new that is not yet known to the patient. In other words, the experience needs to include the therapist's analytical understanding and the patient's insight. Freeing the patient from his secret is predicated on attentiveness to the motion between the clinician and the patient, a kind of joint structuring of the meaning of the secret and a restoration of movement. What is required is emotional attentiveness that can facilitate processing and transforming of what is happening—an attentiveness that creates emotional space in the clinician, repairs the collapse, and brings movement back into the room.

A CLINICAL CASE: THE SELECTION OF THE LIVING CHILD

H is the mother of a five-year-old boy who was diagnosed with cancer. After a year of chemotherapy and radiation treatments, the boy recovered completely and the prognosis was good. H began therapy following her son's recovery. She had begun dreaming that he had drowned, that he'd been buried alive, that he had fallen to his death, and so on. She was terrified by these dreams, and after having one would spend the rest of the night sitting by her son's bed, looking at him, protecting him with her gaze, until she eventually fell asleep.

In therapy sessions, she described her son: a beautiful curly haired child with large brown eyes; a curious child who, it was obvious, wanted to return to life. H was a very attractive woman, 35 years old, married, self-employed. She related that her mother was a depressive woman. Her father had left them when H was very young, and she and her mother moved in with her grandparents. She also related that her grandmother was an Auschwitz survivor. Her grandparents met in Israel and were able to offer each other solace, but she knew nothing about them beyond that.

In our sessions, H repeatedly told of the doctor's announcement of her son's illness, of the dread during the early weeks until the boy's condition and the severity of the illness were clear, of the treatments, of the nights spent in the ward, of the nurses and doctors who talked among themselves

in jargon she couldn't understand. I said: "The hardest thing for you was not knowing." She cried and said that although her husband was a good and caring man and the family was supportive, she felt alone. Ever since her son's illness, H had become an extremely anxious mother, obsessively protective of the boy. She always wanted to know where he was going and with whom, and begged him not to go to crowded places so he wouldn't catch any disease. I tried to talk to her about the feeling of dread when faced with death, and about premature loss of innocence. I felt that it gave H some temporary relief, but no more than that.

It seemed that H could not let go of death, and her grip only got stronger as the threat of death appeared to recede. H began taking her son for frequent (overly frequent) examinations, called the doctor that treated him in the hospital, was in touch with the doctor that treated him in the clinic, and asked about every small change she noticed in him. If the boy didn't have much appetite on a given day, she would consult the doctor. If he had a cold, or felt slightly sore somewhere, she would be devastated. It felt as if the trauma was spreading and becoming incurable. I spoke about the difficulty of being cured and of letting go of the illness, as if there were something about the illness or thoughts about death that one needed to hold onto. It seemed that H was filled with guilt over her son's condition. I thought about her sense of helplessness: There was nothing she could do to ease his suffering, and her mother's love was not enough to cure him. Perhaps her attempts to treat him or control his surroundings were part of a manic defense through which H tried to deny a reality that was out of her control.

Her dreams changed a little at that point. One that recurred involved an open grave for her son, a grave dug especially for him. Was she the one who dug it? She was horrified by the thought. I tried to ask more about it. She felt heavy guilt and shame. Perhaps she was angry with the sick child? Perhaps she felt he had shattered her fantasy-image of the ideal child? She became silent and withdrawn, and retreated into herself. I said that she had secret thoughts that she was keeping from me and maybe from herself as well.

In one of our sessions, H described a dream in which she came down a staircase with her child, trying to flee from some high place. In her dream they were chased by dogs and people. Not finding an escape route, she got angry at her son, saying that it was because of him they had lost their way. H began to rock backward and forward in her chair, crying and hugging herself. In the long silence, and matching the rhythm of her rocking, I could almost imagine the footsteps of a Nazi officer with dogs barking by

his side. I recalled the story my grandmother told me about the moment she was caught on a train by a Nazi officer as she attempted to cross the border from Poland to Russia. I felt terribly afraid. I thought to myself: for who was the open grave intended? Who was buried there, and what is the forbidden topic of conversation here? I remembered the secrets that were like a thread running through the Holocaust story in my own family, and I said: "death and thoughts about death have been with you, perhaps even before your son got sick. Death haunts you, perhaps from your earliest childhood."

She said that she felt haunted and pursued but she didn't know by whom or by what. I suggested that something in her dreams brought me back to thoughts of the Holocaust. I asked her to tell me about her grandmother's house in which she grew up. In the following days, she began to tell me about her home and its secrets. They were not allowed to talk about the Holocaust at all; and, as a child, H felt that she didn't want to know about it, that something in her grandmother's pain was too frightening. Her mother, too, was an especially anxious parent who took care of H devotedly (maybe *too* devotedly), almost invasive in her parenting. Every time she left the house, her mother would tell her, 'be careful when you're out. Be careful'. She never asked her mother what she needed to be careful of, but it seemed she knew more than she wanted to know.

Following our conversations about her childhood home, H asked her mother to tell her more about the war. Her mother told her, for the first time, that H's grandmother had a small child when the war broke out. When the grandmother was deported to Auschwitz, she stood in line for the "selection" clutching her son in her arms. *Her* mother (H's great-grandmother), who was standing next to her, said to her: "There's no point in all of us dying. Give me the baby. If you hold him, you'll die as well." She did as her mother asked—and never saw them again. H's grandmother immigrated to Israel after the war, started a new family and tried to forget the inconceivable choice she had made back then, but she was haunted by her memories and weighed down by the burden of guilt that she was alive and her son was dead.

When H was born, her mother suffered severe depression. Every joyous occasion in H's life was accompanied by rejection and hostility from her mother. H returned to therapy with many thoughts about her mother and the ghosts that secretly followed H from childhood. We talked about the place of secrets in her life, and about there being something in her many secrets that protects her but also leaves her very isolated. In the following months, she began, painfully, to talk about the hostility she felt

toward the weak, sick child, and the feelings of guilt she carried as a result. She was so alarmed by those emotions that swept over her that she turned away from them at once, and they became a kind of inner secret.

She thought about the way her mother and grandmother raised her. She was expected to be strong, not to display any weakness, because her mother was cold and aloof because of her depression, and also because it was their way of protecting her so that she would "pass the selection process."

In the following sessions, H thought about her son and the cruel selection of fate. She expressed the hope that he would pass the selection, and her anger that he had to struggle with the illness. "Why him?" she asked; "Why me?" She talked about the disturbing feelings she had during his treatment. Sometimes, during the treatments, he appeared ugly to her, deformed, and she seldom took him outside, afraid of meaningful looks. She was afraid to think these thoughts, she was so ashamed. It was important for me to tell her that many parents have these thoughts in such circumstances, and that I understood that they were very threatening to her but that these thoughts were normal in such an abnormal situation. I found that processing the living memory of the familial trauma enabled us to return to the current trauma and renew the movement within.

Gradually H returned to herself and to her family. Hopeful thoughts began to emerge. It was possible to think that the open grave, in which the family secrets were buried, could now be closed. No further victims were needed.

I think, in retrospect, that the release of the secret demanded its own broad and multi-dimensional understanding. First, I needed to recognize that H was enveloped in secrets and to speak with her of the experience of harboring secrets, of knowing and not knowing, and of turning a blind eye to difficulties and pain. In addition, I was compelled to keep her disturbing thoughts within me, and to process them through my own unconscious for that purpose, so to speak. It was necessary to process the familial trauma that was frozen as a living memory. Once movement was restored to the past trauma, we could also restore movement to the current trauma.

There were places where, together with H, I turned away from the disturbing thoughts she had about her son. Those thoughts were so terrifying and so powerful that I too was unable to keep them within me. Only when I was able to restore emotional movement within myself and regain the ability to dream of/about H was she able to restore movement within herself. In other words, when the movement of the unconscious within me was renewed, emotional movement within H became possible,

and a joint structuring of the trauma was created. Finally, when H articulated her disturbing thoughts about her son, it was important for me to normalize her feelings by emphasizing that many parents have these thoughts in difficult life situations.

SUMMARY

This article attempts to provide a glimpse of the difficulties that face parents of children with serious illnesses. It examines the terrible feelings of guilt, shame, hostility, and hatred that may well up in the parents toward their sick children. Although such thoughts are natural and legitimate, they produce great anxiety; there are parents for whom such thoughts are especially disturbing. The parents' encounter with their child's illness, and their ability to cope with it, may depend largely on their inner space being devoted to themselves and their ability to empathize with themselves and their vulnerability. Beyond ontogenetic factors, it is possible that the greater the burden of unprocessed secrets the parent carries from his past, and the more he feels that he himself as a child was damaged, hated, and rejected by his parents, the harder it will be for him to confront his own terrible feelings about his child's illness and the child that was himself.

Furthermore, I suggest that the greater the contact therapists have with the murderous and hateful thoughts of the child and the parent in their care, the greater their ability to help release the parents from their secrets, and allow them and their children some space in which to live their lives. The clinician needs to recognize when the parent faced with his child's illness conceals secrets from himself and his environment. Sometimes the recognition occurs through the clinician's inability to think (or limited thinking ability), feelings of fatigue, and desperation, which may be interpreted as projective identification. The clinician may also sense that the parent's experience has become limited, two-dimensional, hopeless, unplayful, and lacking symbolization. In this situation, the clinician's work must be multi-layered, touching both on the parent's struggle with the here and now, and on the traumas from his past which threaten to engulf him. On occasion, for a critical period, the clinician needs to "lend" the parent his own ability to think and to dream, thereby helping the parent renew internal movement. When, during therapy, when parents articulates disturbing thoughts, it is important for the clinician to give them space and affirm their normality.

I recall the story of a young girl, about six years old, who contracted a terminal illness. Her parents concealed her real condition from her, or so they thought. After her death, they found hundreds of notes their daughter

had left around the house. To her sister she had written "be strong," to her parents she had written "I love you," and so on. Her thoughts about her own death could live only upon her death—and thus, for her parents, she could continue to exist after her death. Imagine the things that could have been said to her while she lived and now go unsaid.

Consider that Freud (1905) said every secret will one day be revealed, and that secrets have a compulsion to emerge. Even when they remain unspoken, they hover above us. "He that has eyes to see and ears to hear may convince himself that no mortal can keep a secret. If his lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore" (Freud, 1905, p. 76). Everyone is familiar with such secrets at some level or another. It is no crime to think such thoughts. They are not really forbidden; they are the truth at unbearable moments. And we clinicians need to have the ability to help the parent bring them to the surface.

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Challenges in the Transition to College: The Perspective of the Therapist Back Home

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The percentage of "emerging adults" in the United States going on to post-secondary education is at its highest rate ever. Most are successful academically and socially during the transition. Some students do not adapt as well. These students may settle down after an initial assessment and brief treatment on campus. Others seek help from or are referred to a local mental health practitioner. Among the population of highly stressed (often freshman-year) college students, there is a not-insignificant number who leave school.

Often a return home is viewed by the teen and family as a "failure." The clinician must be a person who can see the potential for growth even in these challenging situations, be able to communicate that stance to teens and parents and remind students and their families that true growth takes time.

KEYWORDS: adolescent development; transition; college; attachment; emerging adult

INTRODUCTION

Many high school graduates go off to two and four-year colleges (Ginder, & Kelly-Reid, 2012). Some of them, perhaps the majority, are successful academically and socially. They tend to be well-adjusted young people who, though nervous when they leave home, manage to find some friends and get along with a roommate. They break through the wall of October papers and exams, and survive past Thanksgiving until the Christmas break.

Some students cannot do this. These are the ones who may access mental health professionals, either in student health services on campus or in private offices and clinics. Sometimes an initial assessment and brief treatment on campus serve to act as "ego glue," and the student settles

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down. These students manage to get from one term to another by relying on either their own inner strength or that of the adults, friends, parents or teachers who offer them help. This fits with the idea that intra- or extra-familial support may influence outcome in this age group when they are under significant stress (Dillon, Liem, & Gore, 2003). Others may seek help from a local practitioner, typically someone whose practice sees students having difficulty making it through college. And, in this population of highly stressed (often freshman-year) college students, there are some who leave school either mid-semester or at the end of the winter break. The decision to leave school is fraught with difficulty, but sometimes is concluded to be the best choice by therapist, teen and family alike. The alternative can be worse.

Often a clinician who sees a youngster who has failed at the attempt to stay at a residential college will meet him or her for the first time just after the return home. The story of the drop-out is colored by how the teen and family view this "failure." The word connotes loss of self-esteem, friends, and position in society. As clinicians, we may be hard-pressed to reframe the situation as an opportunity for growth rather than a failed opportunity to leave home. However, especially for child and adolescent clinicians, seeing children or teens during periods of developmental crisis is nothing new.

The period between 18 and 24 years of age represents the time in the life cycle during which there is the highest incidence of mental illness (Kessler et al., 1994). Because of our knowledge of development, child and adolescent clinicians can play a substantive role in treating adolescents and helping them adjust to psychiatric problems during this period. We frequently tell teens who falter on their way out of high school (failing to "launch") that if they had not experienced difficulties transiting this particular phase of life, they might have experienced similar problems at another moment of developmental transition—starting a job, getting married, having children, etc. As clinicians, we believe that a developmental crisis holds within it an opportunity to mature in ways that the child or adult has been unable to accomplish. This point applies even if the situation at hand is quite serious. Understandably, what is foremost in the student's mind is his suffering; however, the clinician must always see the potential for growth, even in these challenging situations, and be able to communicate that stance to teens and parents.

Once a teen is in serious psychological trouble—either having stayed in school or having returned home—the most helpful clinical attitude to take is that the teen has slowed down the process that is hurtling him towards

adulthood. It is important for the clinician (and family) to see him as *in transition* to adulthood. At least part of the motivation for seeing his struggle as a variant of normal is to engage the teen in working towards a healthier adaptation to stress. If the teen can feel that he is able to successfully navigate a pathway toward more independent functioning, he is more likely to tolerate the potential suffering and social isolation that is likely to ensue with less loss of self-esteem. To help him with this pathway towards adult functioning, clinicians sometimes need to suggest putting on the breaks. This can occur as the teen who has returned home begins to feel better. The impulse to return (prematurely) to school often reflects a lack of understanding about the powerful forces (in the adolescent, family or both) that have been interfering with forward movement, or may reflect a strong degree of denial and resistance to more substantive change.

DEMOGRAPHICS OF EMERGING ADULTS

The demographics and life activities for older adolescents in industrialized societies today are far different from when Erikson or Blos wrote about this developmental period in the early 1960s. The United States Census Bureau in 1997 reported that in 1970 the median age for women to marry was 21 years and for men, 23 years; in 2010 the median age for marriage was 26.1 years for women and 28.2 for men (United States Census Bureau, 2010; Arnett, 2006a). The period from 18 to 25 years has changed during the past 50 years "from being a time of settling down into adult roles of marriage, parenthood, long-term work and a long-term residence to being a time that is exceptionally unsettled . . . " (Arnett, 2006a, p. 7); Arnett (2000) reported that the rate at which high school seniors went to college was at its highest rate ever. It is possible that the choice between continuing on to post-secondary education versus working post-high school is less influenced by the particulars of the activity and more by the adolescent needing to feel that he is moving ahead with his life (Aseltine & Gore, 2005). It does not appear that "emerging adults" (Arnett, 2000) feel that the attainment of a stable career, finishing school, *or* getting married is what will make them into adults; they seem to feel that "accepting responsibility for one's self . . . making independent decisions" is what will finally make them feel grown up (Arnett, 2000, p. 326).

Having a sense of forward motion is particularly relevant for the subset of students who do not complete high school. In a study of individuals who dropped out of high school, Dillon, Liem, & Gore (2003) discuss the role of the loss of a peer cohort. The study highlights individual characteristics that will be called upon for the adolescent to make a successful transition

to better options, such as having more energy, being active rather than passive, and the ability to both accept help from and give credit to others for helping them. This study notes that because the support of the group is missing, "(A) more active coping style is needed for these youth to establish themselves" (p. 438). The study stresses the importance of the connection to and involvement of parents and supportive adults (as well as individual strengths of the teen) that can enable the teen to successfully transit back to high school and increase the likelihood of moving forward successfully.

Epidemiological data reveals a high prevalence of psychiatric problems —on the order of 37%—during emerging adulthood (Arnett, 2006), higher than for any other age group (Kessler et al., 1994). Literature emphasizes that the shift in expectation, experience, stability, and supervision in the post-high school period influences the potential for mental health problems (Arnett, 2000, Arnett, 2000b, Aseltine & Gore, 2005). Alcohol and substance use increase in the teen years, peaking in young adulthood, and spanning college and the first years after graduating from a four-year college (Staff et al, 2010; Maggs & Schulenberg, 2004; Cleveland et al, 2012). Substance abuse can shape the course of emerging adulthood.

Race and ethnic issues are relevant to the transition out of high school. In a study of early family formation (teenage or young adult pregnancy with or without marriage), researchers found a higher incidence of non-marital births at or towards the end of high school among African American and Mexican American young women than for non-Hispanic white females. The lower birth rate is moderated by several factors: higher socio-economic level of families, a two-parent home, and degree of involvement in high school or college (Glick, 2006, p. 1402). For those young adults who enter college, perceived devaluation based on race has an impact on adjustment (Huynh & Fuligni, 2012).

DEVELOPMENTAL CONSIDERATIONS

Adolescent Development

According to Erikson (1963), adolescence is a time during which issues of identity vs. role confusion hold sway, and self-concept is vulnerable to the opinions of others. Many a mediocre role model occupies the podium for some time before the adolescent sorts out who he is and whom he would like to resemble. Peer groups and friendships take on a renewed and important role as regressive urges towards dependency and wanting to belong to a group announce themselves, much as in the earlier latency period. Conflicts with parents, so characteristic of this age, can serve to

assist the eventual separation from the family or to mask deeper issues of unresolved dependency on either side. The adolescent shifts in his sense of his body, significant others and interests; these all have an impact on self-image. The role confusion that Erikson cautioned about speaks to concerns that the teen has about being satisfied with his sexual identity or eventual occupation, or perhaps concerns that he will find neither (Erikson, 1963). Erikson felt that less stable teens (unsatisfied with or confused about identity) were more likely to face additional challenges in preparing to meet the demands of the outside world.

King (2007) outlines tasks of adolescence from early (10 to 13 years) through late adolescence (17 years and older). He writes that acquiring a body image based in reality, having relationships with others outside the parental relationships, drive control and self-concept (including a sense of one's professional future) are tasks of the adolescent years. Like most authors who write on the subject of adolescent development, King is clear that this late phase of adolescence—at least in our modern world—is attenuated. It is often not until the 20s (or beyond) that intimacy, a more mature relationship with parents, and the abilities both to project oneself forward in work and to conceive of having a family of one's own are established.

Blos describes a phase of post-adolescence, writing that "personality development by no means comes to a standstill with the termination of adolescence" (1962, p. 149). Similar to the latency years, in which the real world plays an increasingly important role in the day-to-day life of the school-age child, real life in the post-adolescent years is formative. Post-adolescence is a time in which still-unresolved issues for the teen are played out in the real world—in relationships and in life choices. Blos (1962) writes that an "operational principle" must govern this last phase of adolescence, a phase that consolidates interests, defenses, sexuality and a sense of self, before the teen turns toward the outside world that governs much of adulthood. He suggests this interval not simply as a way to add some time in between adolescence and adulthood proper; he believes that there are specific tasks of this phase, the most important of which is to "come to terms with parental ego interests and attitudes" (p. 156), and for the adolescent to recognize and invest in identifications with parents. The post-adolescent needs his parents, not only to react to and rebel against, but also to help him integrate what it means to become an adult. The post-adolescent reminds us that psychological issues that cannot be resolved by this time period are carried through to adulthood; when these are resolved earlier, self-esteem profits. Goals that have been incompletely

achieved have a way of being dealt with in a less conflictual manner: defenses such as sublimation have the added benefit of moving the older adolescent forward into adult roles as well as contributing to societal values of stability. However, although defenses such as sublimation allow activities such as school or work to help maintain the psychological integrity of the post-adolescent, it is still the capacity for intimacy that remains central to the psychological health of the post-adolescent.

More recently, Arnett (1994; 2000; 2006a; 2006b) has contributed to elucidating the time period. Like Blos, he proposes a new—and separate—phase of development, which he refers to as "*emerging* adulthood" (my emphasis), to be placed squarely between adolescence and young adulthood. A time of exploration and societally accepted lack of constraint by definitive career choice, "emerging adults often explore a variety of possible life directions . . ." (Arnett, 2000, p. 469). Blos (1962) writes that during post-adolescence, adulthood has begun, even as adolescence is ending: both phases of life have a stake. Arnett agrees: he describes its occupants as having a foot in one time period and one in the next.

Impact of Attachment on the Transition to Adulthood

Attachment theory can contribute to an understanding of the transition from high school to college or other activities. Lopez and Gormley (2002) reviewed the impact of attachment on handling "normal" stressors in life, such as going to college. They found attachment style to be moderately stable during the first year of college. Secure students had greater self-confidence and could self-regulate in the face of stress. If students maintain their "secure" status through the year, they are better able to self-regulate as well as seek and use available support systems. Those who became less secure, or did not shift in a secure direction through the year, fared worse, tending to experience more distress as a result of their inability to self-regulate when things got tough. They seemed not to learn or to improve in their capacity to manage stress; they did not achieve a sense of mastery as they progressed. The authors' cautionary note was that it was hard to know what the future would hold for those who had a change in their attachment status through the year, whether or not these changes would last, or if they would be for better or for worse. This fits with the original follow-up literature on attachment security in early childhood by Mary Ainsworth and colleagues (Ainsworth et al., 1978). Attachment security in childhood is consistent through time only when outside factors, such as family dynamics and structure, remain the same.

For all college freshmen, the stress of transition from high school to

college is a relevant outside factor. Park, Edmundson & Lee (2012) studied changes in self-regulation markers during freshman year at a large Northeastern university. As with the previous study by Lopez and Gormley, some students improved in the ability to self-regulate, but many either did not change in this ability or worsened. The specific markers they studied were constructive thinking, emotion regulation and mastery in order to gauge changes in maturity through the year in more detail. They concluded that the demands of the transition to college and freshman year challenge coping skills that students come to college possessing, and that some were less up to the task. Self-regulation ability has an impact on symptoms of anxiety, depression, stress and adjustment to college in freshman year.

The connection has also been explored between strong parental relationships and the adolescent's ability to self-regulate and successfully transition to college. Strong relationships between adolescents and parents and "authoritative parenting" have shown a positive impact on (particularly social) competence (Putnick et. al., 2008; Kazemi, Eftekhar & Solokian, 2010), well-being (Slicker & Thornberry, 2002), and substance abuse (Baumrind, 1991). In a study on the effect of relationships with parents on adaptation of college students, Wintre & Yaffe (2000) measured the impact of "parenting style," "parental support," "mutual reciprocity," and the student's "well-being" on students' adaptation to college. The authors found that both well-being and relationships with parents had an impact on subsequent social and academic adjustment. Kenny and Donaldson (1991) explored the attachment of first-year college students to their parents and found that not only were women students more attached to their parents compared to young-adult men, but also that students who were more attached felt more competent and had more feelings of "well-being." In a study attempting to dissect the relative impact of parental attachment and psychological development to adjustment in college, Paladino, Schultheiss, and Blustein (1994) emphasized the effect of an individual teenager's development on his adjustment in college. Lakey (1989) discussed attitudes and behaviors of students that elicit responses from others in their environment. He reported that those with low self-esteem either devalued or misinterpreted the ability of others to help. Moreover, an adolescent's "distress" made him unaware of available support or unable to discern that his attitudes and behaviors could "turn off" prospective social contacts. Over and above psychological distress, social competence predicted future perceived support: ". . . certain individuals may be at risk for developing insufficient levels of perceived support during major life transitions" (Lakey, 1989, p. 517). Putnick

(2008) found that whereas parental acceptance related to the adolescent's feelings of being accepted, the adolescent's self-concept related much more to how he actually interacted with peers.

CASES

Teen Stays at Home and Works

Jacob was a physical boy born into an academic family. When Jacob was in middle school, his parents divorced. He remembers everything shutting down. At a time when having a father to identify with might have helped Jacob enter adolescence, he was too angry and disappointed with his father for having hurt his mother to have a relationship with him. He could not identify successfully with his passive, disappointing father, and was left to wrestle with an over-controlling, though loving, mother.

Academically, Jacob was a C or C- student at best, and he did not do anything to excess—including studying. It was probable that he completed his secondary education with both an undiagnosed learning disorder and attention-deficit disorder. Although in his late teens, he had accomplished little in the way of mastery of the adolescent tasks that one would expect. Had he been born in an earlier era, Jacob might have stayed home after high school and gone to work or trade school; a two-year community college away from home proved to be too much. While he was blissfully content away at school, with having escaped his home and having a good time, he had been unprepared for the academic load and unready to structure his time so that he could pass his classes. He was asked to take an academic leave and return home. He found himself back in the one place he had wanted to escape.

Treatment with Jacob consisted of helping him manage both his tendency towards impulsivity and his difficulty in realistically assessing options and considering consequences. Treatment was eclectic in nature, as these sorts of treatments tend to be—at times more psychodynamic, at times more resembling the ministrations of a camp counselor, and at still others, dedicated to (somehow) helping his family work on reasonable communication. He increasingly recognized the importance and helpfulness of having a solid, though, at times, vulnerable, relationship with his parents. After many bumps in the road, Jacob began to act in a more age appropriate manner and to take some personal responsibility. Although the outcome was not necessarily comparable with others of his age, he was able to hold down a job and take courses, and was in the process of saving to hopefully someday have a place of his own.

Teenager Stays Home and Attends a Four-Year College

Borderline pathology and difficulties in her relationship with a volatile mother characterized Stacey's junior-high and high-school years. She had a hostile-dependent, tumultuous attachment relationship with her mother; Stacey became an expert in dissociating during untenable fighting with her. Not atypically, she used what was at her disposal to numb the pain—non-suicidal self-injury became an escape, which would later be replaced by drugs. Stacey's tendency towards the paranoid negatively affected her social relationships. She thought that she was too "stupid" to learn much at school. Because Stacey's family was inclined towards a hard-work ethic, Stacey always took on jobs at home, and, as soon as she was old enough to work, found someone in the community to hire her so that she could become a wage earner. The end of high school was calamitous. Several college options failed, she had multiple ill-advised romantic relationships, and impulsive, self-destructive behaviors led to several hospitalizations and attempts at treatment with medication.

Stacey's individual treatment, begun in high school, as well as work with her parents over many years, allowed her to begin to address her relationship with her mother and the multiple losses and developmental arrests that had ensued. Not having been able to "make it" in school away from home, Stacey eventually chose to matriculate at a local college, which she attended while living at home. Although at times Stacey continued to be symptomatic because of the generally vulnerable nature of her character structure and defenses, she was able, finally, to embrace the family work ethic while simultaneously begin to acknowledge herself as a good student, and eventually begin to consider post-graduate education and a possible career ahead.

Teenagers Attend Four-Year Residential College

Kevin

Kevin was an interesting, bright, overly sensitive teen. Plagued with self-doubt from childhood, he was a middle child set between an over-achiever and a social butterfly. Despite treatment for a dependent relationship to his mother, Kevin had difficulty separating from home; episodes at sleep-away camp were tolerated, but multiple phone calls home were required. The transition to college was overwhelming.

He felt that there was no one he could turn to at college, but his personal drive and work ethic was to shoulder through, somehow. After developing panic attacks, and very nearly leaving school, he became engaged in a private psychodynamic psychotherapy after a brief consulta-

tion with his college mental health service. His parents were encouraged by the therapist to understand and accept that Kevin needed time to work through issues that had not allowed him to mature during his high school years. Kevin, though having great potential academically, was immature and vulnerable; he needed the ego support of the therapist to get him through the rough patches during the college years. Eventually, Kevin began to make some friends and think about a career.

Fran

Fran was a beautiful young woman who had difficulties since childhood with fragile self-esteem and significant sibling rivalry with her even more beautiful sister. Much like the queen in Snow White, no matter what Fran did, her sister seemed to prevail at winning attention from boys, affection at home, and a privileged position in the family pecking order. Through the biological coincidence of the growth cycle and burgeoning puberty, one day she found herself *almost* as beautiful as her sister. The development in high school of some symptoms of an eating disorder served to both keep Fran thin and keep her anxiety in check.

Fran turned to other forms of non-suicidal self-injury for mood regulation. Psychotherapy during her high-school years focused on self-understanding as well as affect-regulation. Periodic parent sessions helped her parents to accept the amount of time necessary for Fran to establish trust in the treatment in order to reveal her difficulties. Individual treatment also addressed Fran's separation issues in an enmeshed relationship with mother.

Despite treatment in high school, transition to college was rocky. Continued phone sessions and direct contact over vacations and holidays were able to build on work that had been done in high school. Away from home, the Fran was finally able to disclose more about her eating disorder, and she began to work on it in earnest. She considered the option of seeking therapy closer to college. She also began to consider a post-college career and a graduate degree.

DISCUSSION: ADJUSTMENT AFTER HIGH SCHOOL FOR TEENS AND FAMILIES

Each of the cases described above represents an adolescent who faltered in transitioning out of high school. They differed in economic background, home environment, and priority given to academics in their upbringing. They represent a range of psychiatric diagnoses, and as a group, they represent high school students at risk to not "launch" easily to

college. The outcome of an adolescent in terms of the level of academic achievement post-high school is only one issue in these or similar cases; productivity, happiness, and the ability to have satisfying relationships concerns us even more as child and adolescent mental health practitioners.

Looking at them through a different lens, all of the cases cited in this paper can be seen as having variants of an anxious attachment. For example, Stacey's increasing—and then debilitating—difficulties in affect regulation and her self-destructive actions can be seen as related developmentally to an ambivalent attachment. However, despite serious difficulty between Stacey and parents, her home was at the very least a known quantity. Moving away taxed her ability to accurately perceive her environment, self-regulate and access support. These cases represent a longitudinal way of thinking about young adults traversing one of the more challenging episodes of separation built into the life cycle; those who have weakness in their attachment style will have greater challenges navigating this time period and leaving home.

In the cases presented, there are examples of limitations in authoritative parenting and the result of these limitations on self-concept. When a young adult is trying to separate from home, dealing with over- or under-controlling parents may force him into feeling that he has already accomplished the work of separation (prematurely), or cripple efforts to see himself as separate from parents. It is the experience of this author that, despite the age of these youngsters, work can still be done with the college student who needs to return to the parental home (or the one that remains in school) that will allow forward movement in the relationship between parents and teen. However, involving parents, particularly working in the context of college mental health services, is complicated by legal issues (see "Family Educational Rights and Privacy Act"- FERPA). If parents are unavailable, or if either the student or parents are unwilling to participate in working together with the therapist, the therapist can work individually with the student to address ways in which his immaturity may reinforce parental behaviors, or to help him cope with parental behaviors that make it challenging for him to grow up and separate effectively. Work on attachment may also assist vulnerable students not only with establishing the level of support needed from the adult community, but also with whether—and how well - they can "metabolize" the support. Knowing both how much support to offer a student and the student's capacity for using that support are factors a therapist may use in helping parents make plans with their vulnerable, late-high school student. What should be emphasized in clinical consultation with patients and families facing

difficulties during this critical phase in the life cycle is the amount of time required to allow for the transition to adulthood after it has been derailed. True developmental growth requires time; as adults who wish to welcome these "emerging adults" into our midst, we need to offer them our time, patience and dedicated treatment.

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Numbing After Rape, and Depth of Therapy

PETER BARGLOW, M.D.

After great pain a formal feeling comes –
The Nerves sit ceremonious, like Tombs;
The stiff Heart questions 'was it He, that bore,'
And 'Yesterday, or Centuries before'?
. . .
As Freezing persons recollect the Snow –
First – Chill – then Stupor – then the letting go –

Emily Dickinson, 1890[1]

The author considers the reactions of four women who had been sexually assaulted, with a focus on the rape trauma of two women with the diagnosis of "Complex-PTSD." Both patients also had prolonged episodes of illegal drug dependence. The article investigates a variety of therapeutic responses to ameliorate disabling post-rape psychological symptoms, especially an intense feeling of numbing. Psychodynamic treatment was chosen for investigation rather than Prolonged Exposure (PET), or Cognitive Behavioral Therapy (CBT). Choice of these two treatments is supported by substantial statistical evidence. But many therapists continue to use psychoanalytic based approaches to treat rape victims. Schottenbauer et al, (2008) concluded that PET and CBT approaches had high non-response and dropout rates. Also psychodynamic comprehension may be particularly suitable for "complex PTSD" as defined below in this article.

Two vignettes contrast the treatment processes and outcomes of these two women to two other patients who had been sexually assaulted, but whose psychopathology was less severe. The author proposes that full comprehension of severe numbing is essential in the selection of the best intervention

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strategy because this symptom (or affect) may determine the prognosis of raped patients.

KEYWORDS: Complex-PTSD; rape; therapy; numbing; trauma

INTRODUCTION

Rape is experienced always as a terrible trauma associated with terror, pain, and fear of death. It persists as a brutal common crime in all parts of the world. Recent estimates indicate 17 % of US women are sexually attacked during their lifetime (National Institute of Justice, 1998). Men constitute a small minority of its victims, and as yet there is a paucity of data describing their post-trauma symptoms. Most treatment specialists in regard to children distinguish rape from abuse, but the boundary between them is often indistinct. Psychological information about treatment of raped children and its effectiveness is sparse, because of moral, legal, and religious taboos. The hundreds of articles about the victims of female rape incidents recognize that male violence, power, and rage fuel assaults, more than sexuality. But a definition of rape as "a sexual relationship to which one party does not consent" captures a broad widely accepted contemporary meaning of this word with a quite different connotation than it had during medieval or classical eras. Despite progress in securing women's welfare and rights during recent decades, amelioration of both the protean painful and durable psychological symptoms after a sexual attack continues to pose a difficult challenge. While I am now an older psychoanalyst specializing in addiction medicine, formerly I was a younger associate professor in an academic department of obstetrics and gynecology. I have treated and followed up with many rape victims some for decades. Many of the patients had had considerable psychopathology prior to the assault because of poverty or psychological mistreatment during childhood and adolescence.

At the outset of this article I need to summarize my concept of "severe emotional trauma". I adopt much of the eloquent descriptions of Stolorow, 2007. Overwhelming emotional trauma represents and reflects the unbearable feeling that one's inner world is unstable, unpredictable, and even dangerous. Individuals that have this shattering experience are "stripped of an internal presence of more powerful guardians unconditionally protecting them from harm." (Prager, 2011, p. 429) Numbing and/or psychosis are psychological remnants and reminders of a shattered once safe, albeit illusory universe. Individual victims vary in their capacity to tolerate

the external world's horrific events such as torture, starvation, imprisonment, warfare and rape. The quality, duration, and intensity of external traumatic events are important determinants of traumatic states. But the inner subjective abiding solidity of relationships with other beloved humans such as parents, offers some protection and possibilities for repair and recovery.

I treated the four women in this report with psychotherapy and some medication for at least three years, all prior to the recent 2013 publication of DSM-5. The present contribution reconsiders psychodynamic psychotherapy methods with a focus especially upon more severe psychopathology. I emphasize, especially, the major importance of the symptom or feeling of numbing. I use most of the criteria of DSM-IV and DSM-5 to diagnose posttraumatic stress disorder in both the first patient, who had comorbid poly-drug dependence, and in the second patient, who had episodes of methamphetamine misuse. In the case history of the second woman, a victim of childhood rape with a co-morbid stimulant addiction diagnosis, numbing possibly may have been present during early life. But after being re-traumatized by adult sadistic, sociopathic male partners, and sudden abandonment by her children, her numbness had an intermittent presence.

The diagnostic features in both instances fit the rubric of "Complex PTSD." I will summarize the salient features of this diagnosis, evaluate the symptom of numbness, and discuss their implications for therapeutic approaches. Several research studies cited below, published prior to 2013 considered numbing symptoms of considerable importance for prognosis as do I. For purposes of contrast and comparison, I present two other brief treatment summaries that describe emotionally healthier patients, also survivors of an attack incident. Their reactions to acute trauma were characterized by brief or only mild numbing symptoms and both had successful treatments. The first two patients' histories are more detailed than typical examples in statistical research trauma articles. My descriptions of treatment interactions are intended to provide renewed stimulation for therapists to reconsider the role of the numbing phenomenon in the psychotherapy of victims of a rape crime.

THE PTSD DIAGNOSIS APPLIED TO RAPE TRAUMA

Most psychiatric research has studied the post-incident suffering and disability of raped patients using the PTSD symptom clusters found in the *Diagnostic and Statistical Manuals* (DSM) of the American Psychiatric Association. The World Health Organization's (WHO), *International*

Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) mental disorders classification system is similar, though it has been used to a lesser extent in the United States. The WHO's ICD–10, like the DSM-5, (both of these the current iterations of the publications), places an emphasis upon the defenses of dissociation and conversion. Both the DSM-IV and -5 contain a criterion for PTSD that states the patient must have been exposed to an event of threatened death, or dangerous threats, or sexual violence. The target population systematically studied to establish and validate the PTSD diagnosis in the DSM has been war veterans, and for the recent DSM-5 reliability research (2012-2013), the adult population was found mainly in the United States Veterans' Administration hospital system. But the PTSD diagnosis also has been applied broadly to assessing the trauma of rape. Women have a greater risk of developing PTSD after physical assault than do men (Betts et al, 2013).

The validity of all the DSM has often been criticized, but particularly DSM-5. While I have contributed to this negative view especially with regard to the PTSD diagnosis (Barglow, 2011, 2013), I consider this nosology to be a comprehensive, quantifiable description of the consequences of traumatic experience. The *Diagnostic and Statistical Manual* criteria are the best current source of research data to compare alternative methods of treatment with many varieties of psychopathology including those specific to rape trauma. The psychiatric diagnosis PTSD first included in the 1980 DSM-III lists the symptoms of intrusive recollections, nightmares, psychic distress, or physical reactivity to reminders that leads to avoidance of some thoughts or situations, insomnia, irritability, and hyper-vigilance. There may be poor recall of disturbing experiences with a new "numbing of general responsiveness" or restricted affect. The description remained the same in DSM IV-R, and its nosology demonstrates very high reliability for the PTSD diagnosis after its transfer to DSM-5 (Freedman, Lewis, Michels et al, 2013). The DSM-5 with regard to PTSD mentions psychological symptoms and feelings often tantamount to numbing, citing decreased involvement in habitual activities, a new detachment from formerly important persons, and absence of habitual pleasures. However, it uses the term "numbing" as type of culture-related symptom. The DSM-5 classification of PTSD appends the presence or absence of coexisting symptoms of depersonalization or derealization, which are separately considered to constitute a Dissociative Disorder in the DSM-5. To qualify for inclusion, these two symptoms, often associated with psychotic states, must not be the product of intoxication or another

medical condition. I prefer to consider them to be more malignant aspects of severe numbing, as they were in DSM-IV.

Typical post-trauma responses to rape comprise a Posttraumatic Rape Syndrome compatible with descriptions in the DSM-IV R of flashbacks, nightmares, startles, phobias, depression, avoidance, and numbing for PTSD. The relevant emotional defense process, extrapolating from concentrated combat exposure research, is "peritraumatic dissociation." In a study of 251 male Vietnam veterans with high war-zone stress, "the greater the dissociation during combat stress exposure, the greater the likelihood of meeting criteria for later PTSD," (Marmar, Weiss, Schlenger et al, 1994, p. 902. In the first two patients described here, besides numbing there were considerable symptoms of depersonalization and derealization, also emphasized as related to PTSD descriptions in DSM-5. Comorbidity with substance dependence, depression, and anxiety disorders other than PTSD is typical of a large portion of the population of women who have been raped. To introduce my effort to comprehend more thoroughly the numbing feeling, affect, defense or syndrome, I will start with a self-report of a young woman, for whom this condition was paramount among her disabling post-trauma symptoms.

CASE EXAMPLE I

On the day my patient, aged 25 years, was raped she had almost completed a PhD. On that Thanksgiving Day my patient was taken hostage and brutally raped by three strangers who broke into an abandoned house of a friend where she was living temporarily. She reported:

> Afterwards, I was unable to stagger more than a few steps at a time, due to genital [damage] and eye injury from being punched in the face. I was getting over a cocaine binge without any friends or family, with no possessions or money, in an unfamiliar empty neighborhood. The cops forced me into a psych-ward for suicide danger, where I was examined coldly, detoxed, medicated and thrown out.

Numbing came soon afterwards, described as follows:

> It came as a surprise to me that as time passed I still felt little to nothing about the rape. I was increasingly bewildered at the odd numbness surrounding the entire rape incident. I would check up on it every so often in my mind, like a person whose tongue wiggles a broken tooth or cavity, to see whether my mind had changed—or rather, whether any new feelings had developed. But it all still feels like a blurry sequence of dreams, it's a videotape with the sound turned off. Drugs did play some part in buffering

my terror or remembering it, but they seemed not to affect my clear recall of every detail.

Some of my recollections are weirdly new, and they change over time. I do often remember that during the rape by the crazy man who first took me captive, after he punched in the face and threw my cell phone away from me, I kept saying, "Sir, please stop doing this. Why are you doing this to me, sir?" I repeated "sir" over and over again, while this crack-addled street hustler was doing sexual acts on me. Yet now today I still feel totally nothing or numb about the event–people around me seem to feel worse and more awkward hearing about it than I myself do in thinking or talking about it. I recall the event like a third person observer of the vacant rooms and mechanical motions during the hours that I was held captive. The wasteland limbo in which I currently reside is a world between worlds, where I wait to be born like a Tibetan Bardo. I have an impersonal visual perspective on the events in which tiny details usually are clouded and nebulous. But without any prompting, silly clear things come up; like I can see like in a museum painting, that specific abandoned street in streaming rain having the odd idea that in a nearby shack, some family was having a cozy holiday dinner. My rape has forced me into a totally new life: It gives me terrifying nightmares, has ended my student days, and made me choose a nun's lifestyle. It's strange though that most daily experiences seem emotionally disconnected, unreal and impermanent.

While having considerable derealization, and transitory depersonalization during the attack she manifested some immediate resilience shown by her odd politeness to an attacker. Perhaps strength was shown also in the capacity to retain a positive image of group safety shown in the family dinner fantasy. The patient during her post rape-trauma emotional life experienced the pervasive perception of numbness as her single most painful and disabling symptom. A few details of her childhood are pertinent to her strengths and vulnerabilities. More nuanced early emotional memories were almost entirely missing fully compatible with generalized dissociative amnesia. But I doubt if she had any emotional numbing then, an observation compatible with recollections of her parents when they were asked about this in a recent year. (In this regard she differs from the patient in Case Example II who suffered more extensive and chronic childhood trauma, and who did have early numbness, and "zoning out" periods.)

The patient was born on a small farm near Banja Luka, Serbia, and while her overall memory of the first years of life was quite poor, she remembered the sweetness of being sprayed with warm cow milk. She recalled that she seemed older and more mature, and disliked same-age

playmates from Croatia (implying that even then, as a child, she knew of current political reality). She recalled little adversity or pain, but suspected that much turmoil resulted from her biological father leaving the family when she was a child of three. Her mother left the rural area and studied music at a local college, where she met the patient's stepfather, then a student journalist. Her mother married the student, and when she was seven years old, the family moved to Belgrade during the onset of the Third Balkan War.

Her stepfather was hired by a Serbian media propaganda group and was successful as a writer. She liked the sound of his voice, adored his reading books to her**,** and recalled that he gave her a small diary, which she treasured, and now associates with her pleasure in writing. Frenzied political struggles engrossed her father, who rarely lived at home for more than a couple of days at a time, and who started having numerous sexual affairs with a series of younger women. Her mother suffered from severe migraine headaches and chronic back pain, making it impossible for her to be employed. The patient recalled her mother not so much as in motherly role, but more as a friend who protected her from her father's malice and condemnation of female fragility. Her mother avoided any display of irritation and when confronted by adversity often played the role of clown or buffoon.

During most of her childhood my patient felt she had been mistakenly "trapped in the body of an adult." She always felt compelled to avoid trouble (as her mother did) and to exercise control over both positive and negative feelings. Since her father wrote for a radio station detested by members of other ethnic groups, he felt (possibly correctly) that he and the family were being spied upon. Because the patient was "super-smart" (by her own description), peers bullied her as a "teachers' pet," and adults were condescending or ignored her. To survive emotionally she attached herself to a popular athletic girl, and maintained a secret unrequited love for an older boy. At the age of eight, her main relationship was to her diary, in which she shared her unhappiness, resentments, and hatred of her lonely life.

At age 17 she was sent to the United States with a full scholarship to an Ivy League college. But soon after matriculation she established social ties with school dropouts, town vagrants, troublemakers, and "druggies." She began using euphoriants, leading to intermittent mild addiction over the first three years of enrollment. Miraculously, she performed well in classes and was considered a gifted, brilliant student; she particularly excelled in

fiction and writing classes. She recalled no numbing episodes during these years.

Since being attacked, there were a few occasions she barely survived physically, and she contemplated suicide. Eighteen months after treatment started, she required two more hospitalizations both much shorter than the one she needed after being raped.

At the initiation of treatment, she totally avoided both sexual life and emotional intimacy, was plagued by various obsessions about food, doubts about her work capability, and physical attractiveness. She controlled these doubts through prolonged exercise activities and dieting, which she regarded as soothing distractions, but which often exhausted her emotionally and physically. Her parents helped her a little financially, but still lived in Europe, and mostly ignored her. She was unwilling to have contact with American relatives who tried to reach out to her, perhaps because she was too ashamed of her addiction problems.

At times she worked as an administrator and peer counselor in a "safe-habitat house" treatment program for people with addictions, where she lived in an unheated attic room. She attended Narcotics Anonymous meetings regularly and did not have cravings for illegal agents or suffer a drug relapse. Abstinence was supported by a daily high dose of buprenorphine (24 mg.), an opiate maintenance agent. The use of this legal agent prevented menstruation during the first three years after the rape. She was comfortable with this situation in spite of a slight risk to her ovaries because menstruation reminds her of sexuality and rape. She also took small doses of antidepressants and benzodiazepines. Often, magical thinking attracted her to alternative medicines that were promoted in partial hospitalization programs. I discouraged the use of these, if they posed a risk.

DISCUSSION OF CASE EXAMPLE I

The therapy strategy evolved not so much from her early history but from her more recent status, including illegal agent use just before the rape and from her precarious mental status post-incident. In this patient's treatment, I chose an approach that was supportive of her surviving psychic defenses and deliberately avoided psychological depth. Her primary psychotherapist had a similar approach—we avoided deep psychological interpretations or reconstructions, and we rarely spoke of her traumatic past. Early in her treatment during a monthly medication checks, I often chatted superficially with her. When she found it too emotionally difficult to meet with me, she sent me extensive e-mails detailing her

chaotic life. Sometimes I gave her direct advice about daily tasks of living. Also she had supportive therapy once a week or every two weeks with an empathic older woman. The patient's creative writing was clearly a good way to remain emotionally connected, and was cautiously encouraged by both of us.

The distressing sensations of numbing were prolonged, paralyzing, and painful during the first year of treatment. It is possible their presence and duration were increased by the use of legal buprenorphine, even in the absence of illegal drug use.

During the second therapy year she suffered more bouts of anxiety, insect phobias, considerable anhedonia, and hypochondriasis. We noticed once that when she had a six-to-seven hour bout of numbness, triggered by a strong flashback reminder of the rape by a menacing man, she felt less agitated and fearful. But the simultaneous heightened derealization lead to serious temporary mistakes in judgment and decision making and lead to exposure to other real risks. Yet, the patient increasingly managed to feel safe and comfortable with both me and the other psychotherapist, an attitude gradually transferred over several years of time to her social life outside of treatment.

Using the description of ego growth phases outlined in the writing about trauma of James Chu (2010A), she attained "Phase II of Trauma Repair," in which she could confront and work through some of her traumatic memories. Numbing symptoms diminished markedly during the second treatment year, while the dose of the opioid agent buprenorphine remained the same. Numbness was brief and rare during the third treatment year. At the end of this year her dose of buprenorphine was diminished by 20%, and she had more symptom-free days. She managed to establish durable non-sexual friendships with several men who were both protective and generous to her.

The diagnosis of Depersonalization/Derealization Disorder does match all of this patient's symptoms and treatment course events. However, there was no numbing prior to the rape, and we were unable to verify that she was exposed to substantial abuse, violence, or neglect in childhood. Her many years of academic high achievement also speak against this diagnosis. Considering her history of drug dependence prior to the rape, my patient's diagnosis met all the criteria for the designation, "Complex PTSD." This term describes the pathology of trauma subjects with a background of repetitive and chronic traumas (Muenzenmaier, Spei, & Gross, 2010), or disorders of extreme stress producing major co-morbidity with depression, addiction, and Axis II Personality Disorders as described in the DSM.

Illicit drug use increases the risk of future sexual assault and assault increases risk of subsequent substance dependence (Kilpatrick, Acierno, Resick et al., 1997).

Could the patient in this case example have been helped more by intensive therapy or even psychoanalysis? Ullman & Brothers (1988) emphasized the benefit of analytic approaches for even severe trauma treatment. They consider the advantages of "insight" versus "supportive" therapy, and compare the "psychology of the self" understanding with traditional Freudian perspectives. Ullman and Brothers (1988) might have recommended that for this woman we should identify the archaic, narcissistic fantasies that were shattered by the sexual assault. (They acknowledge that some analyst writers have warned of risks associated with depth analysis of severely traumatized patients.) These fantasies they maintained, even if weakly restored can be "precursors of the more familiar dissociative symptoms of PTSD such as re-experiencing and numbing" (p. 118). This idea seems a little too speculative, but we could not identify such a childhood cognitive-affective nucleus in this patient anyway.

Localized dissociative amnesia was a tough impediment to efforts to reconstruct details of her early emotional infantile conflicts and injuries. This was not shown in regard to memory of details of the rape incident, but was manifested more in regard to her experiences as an addict. Her other therapist and I noticed loss of remote memory most dramatically in the blanket of silence covering early childhood: "I was never a child." Years of illegal drug use might have impaired recall, but the influence of this factor was difficult to judge. Ferenczi (Gutierrez 2009) noted that unbearable trauma could destroy the self, through the mechanisms of "concussion," "splitting," or "atomization," which may generate a psychosis. It is possible that therapists who fear to use classical psychoanalytic methods, such as transference interpretation and reconstruction of childhood narcissistic wounds, may be over-identifying with victims of injustice. The second summary of a treatment captures even more vividly the importance of transactional empathic timing, and the utmost caution required to treat a severely traumatized rape victim.

CASE EXAMPLE II

Alberta is a divorced 55 year-of-age teacher. She is physically small, with blonde hair, and a smooth doll-like face that at times is perturbed by twitches of tardive dyskinesia. She has two daughters and three grandchildren who are very important to her since they constitute almost her sole

social contacts. At the beginning of her treatment the only medicine she used was aprazolam, an agent with the frequent side effect of memory loss.

Alberta's early life was chaotic and dangerous. Her father was schizophrenic and alcoholic and resided more in mental hospitals and jails than at home. Her desperate impoverished mother abandoned her at the age of two, and after a year in an orphanage Alberta was placed into an unprotected foster home care situation. As the youngest of 10 children she was severely neglected by often-changing care providers. Half a century prior to my treating her, between the ages of three to four years, she was raped and badly bruised by a 19 year old mentally impaired foster-brother. She recalled that afterwards,

> I was in a total daze. I shut down, everything went in slow motion, and I became mute, could hardly hear, and could not look anyone in the eyes for several days. He ordered me to forget about what happened, and I was determined to no longer remember anything.

There were further episodes blurred by the fog of time. Unbearable repeated childhood terror, I speculate, was the progenitor and nucleus of later adult numbing.

She was married for a few years, and after divorce had some durable relations with men. But men tended to exploit, deceive and verbally abuse her. After her daughters left home as adults, Alberta reported some days of fogginess, disorientation, depression, and craving for stimulation. During her 40s she became addicted to crystalline methamphetamine and sometimes became paranoid during heavy use episodes. She almost recovered from this addiction, and had had many drug-free years during which she was assisted frequently by therapists and psychiatrists. Still she had periodic severe panic attacks, and sometimes cut her wrists after stressful life events. When numbing dominated her mood she would make errors of omission. She might not appear at her job, without offering an explanation before or afterwards. Antidepressant medication provided some relief, but she often stopped taking it because of various disagreeable side effects or because of "forgetting" to take it.

Treatment Issues and Problems

Once during a treatment session Alberta was talking of being abandoned by a man she had dated recently. Suddenly she recalled that a few days after her childhood assault experience, she had shut out awareness of her own external genitalia. Then she recalled a "disgusting" memory that she has not told her previous therapists:

> I saw on a cover of *Life* magazine, a picture of infant girl Siamese twins

> joined at the hip, with their genitals showing. I tried to hide the picture by laying a book on the picture.

I might have used this memory to talk about shutting out her embarrassment about having once again trusted a stranger without considering that he might turn out to be a selfish exploiting male or I might have further explored with her, feelings connected with her childhood rape. But I responded only with a terse comment, "you must have been very scared."

At that moment I did not pursue the memory at all, made no interpretations, and did not try to use it for purposes of reality testing. Instead I chose to support the defenses of repression and suppression. My response may seem incompatible with the challenge of "recovery of dissociated emotion and knowledge . . . and restoring or acquiring personal authority over the remembering process," by Courtois and Ford (2009, p. 90) as suggested for treatment of this sub-type of PTSD. But the abrupt revival of this undefended bizarre explicit graphic image seemed near to psychotic deterioration. The time was not ripe for efforts to counteract either dissociation or repression, and there might never be such a time. (Later while preparing this article, I searched for such an image in *Life* and *Time* magazines published during the specific years of her early childhood, but could not find any such photo of Siamese twins. I did locate a graphic image of thalidomide-deformed joined-at-the-hip female fetuses that the patient may have glimpsed as a child.) After this incident the patient had a sustained period of emotional stability.

But nine months later she had a relapse in crystalline methamphetamine use. This lead to the fierce angry criticism by one of her daughters and a several month long period of social rejection by the other, who herself felt more emotionally fragile after the birth of her own infant. This familial friction, reinforced by her insensitive ex-husband, was the precursor of a situation in which the patient's daughters disinvited her from a planned family vacation. Alberta took this as a vicious rejection, and she had a near psychotic-rage reaction during which she yelled loud threats of violence. Alarmed neighbors precipitated a massive police intervention and involuntary psychiatric hospitalization. After I learned she had been discharged I scheduled an early therapy meeting with the patient.

She was still agitated and immediately directed her verbal fury toward me, to which I responded clumsily and inappropriately. Perhaps too quickly I surmised that she was not overtly paranoid or delusional. She tried to avoid exploring either the slight from her daughters or the details of the hospitalization. She insisted that she only sought a few-minute

meeting to renew her sleeping medications (Alprazolam, 2.0 mg). I wrote the prescription, but I commented that I could understand how in light of her drug relapse, recent irritability, and work absenteeism, her daughters might not have wanted to expose themselves and their very young children to her unpredictability. My error reproduced in Alberta both the terrifying perceived abandonment by her daughters and the intolerable pain of her horrific early childhood traumas. She screamed invectives at me with intense vehemence. She suddenly bolted out of the room, almost smashing the exit door, jumped into her car, and drove away at such a high speed, I feared a serious auto accident.

Van der Hart, Nijenhuis, Steele (2006) would comprehend this behavior as a "maladaptive substitute for adaptive action" which revived earlier life hyperarousal while demolishing reflective thinking and realistic action (p. 27). Two days I phoned her to schedule a meeting. When we met, I referred to the recent traumatic situation only while entirely taking her side: "You were entirely justified to be outraged. But maybe you could use anger at such a rejection more in your behalf next time, and avoid going into the hospital".

It appeared I could at least temporarily assist her to master recent events more calmly and realistically. But after three years, while she has improved in her capability to work at a job, participate fully in Alcoholics Anonymous, and develop new friendships, she remained profoundly impaired. She had not fully attained the completion of the first phase of Complex Trauma Repair (Chu, 2011). This partial failure may have been explained by periodic addiction relapses, my therapeutic mistakes, or by her inability to better master the extraordinary agony of her early continually childhood traumata, revived in her contemporary life.

The Importance of Numbing in Comprehending Aftermaths of Emotional Trauma

I find that numbness is the pivotal condition or symptom in selecting an optimal strategy for psychodynamic treatment. In the DSM-5, PTSD (309.81) and the Dissociative Disorders–Dissociative Amnesia (300.12) and Depersonalization / Derealization Disorder (300.6) attribute the proximal cause of numbness to the mechanism of dissociation. "For PTSD, dissociative processes manifest as emotional numbing" (Chu, 2010, p. 615). Deeper understanding, description, and elaboration of this symptom might further clarify the prognosis for rape victims, and might even provide a guideline for selection of a type of psychodynamic treatment–"supportive" versus "uncovering."

Persuasive evidence shows that the important psychological defenses of avoidance and numbing are distinct (Asmundson et al., 2005; Pruneau 2008). Clinically viewed, those patients who actively avoid perceptions and environments reminding them of a specific severe trauma manifest considerable control and mastery. The former defense seems healthier and more mature than the latter. Those suffering from pervasive numbness appear to suffer more from sensations of helplessness and being overwhelmed by a distressing void of emotion as described in the first two subjects in this article. This observation is aptly captured by the summary quotation by Feur, Nishith, and Resick (2005) of the assertion of Taylor, Kuch, Koch et al, 1998 that "Numbing is an automatic consequence of uncontrollable physiological arousal whereas avoidance is an active means of coping with trauma-related intrusion" (p. 166).

Severely traumatized patients with preexisting psychopathology, as illustrated by the above first two case examples, may be characterized by a specific dissociative subtype of PTSD that involves disruptions in the functions of memory, identity, body awareness, self-perception, and relation with the environment, When this PTSD category is considered from a neurobiological perspective it implies "emotional over-modulation mediated by midline prefrontal inhibition of limbic regions" located in the dorsal anterior cingulate, and medial prefrontal cortex, (Lanius et al, 2010, p. 640). Flack, Litz, & Hsieh et al (2000) proposed that emotional numbing is the result of chronic hyperarousal in male combat veterans. Amnesia, detachment sensations, lowered emotional responsiveness, reduced awareness of inner feeling nuances, conviction of a foreshortened future, and suicide wishes characterize a corresponding psychological numbing condition after rape.

Studies of combat veterans find that numbing often predicts an increased incidence of future anxiety and psychotic disorders (Kashdan et al, 2006) and predicts chronic PTSD, (Marshall, Turner, Lewis-Fernandez et al, 2006). Numbing symptoms in disaster workers predict future intractable PTSD (Malta, Wyka, Giosan et al, 2009). Also, it has considerable predictive importance for the employment of specific treatment modalities (Foa, Cashman, Jaycox, Perry, 1997, and Pietrzack 2009). Nishith et al, (2002) found that exposure therapy works better to reduce avoidance than it does to ameliorate numbing. Numbing seems to be more associated than does avoidance with major depression syndromes and implies a worse long-term prognosis. Holowka, Marx, Kaloupek &Keane (2012) reported that Vietnam war veterans with simple PTSD reported more numbing/restricted affect symptoms that did those with PTSD and comorbid

disorders. Of course the frequency that numbing is reported may differ between male war veterans and female rape victims.

The symptom of numbing is incorporated in two quantitative scales of Psychological Test Instruments that measure improvement in the PTSD clinical condition. One is a Clinician-administered PTSD Scale ([CAPS] Blake, et al., 2006) and the other used patient self-report (Foa, Cashman, Jaycox, & Perry, 1993). Both scales to a large extent mirror the symptom categories from DSM-III-R, in which numbing is included in "Avoidance-Numbing criterion C." These psychological test instruments in subcriteria (C3-C7) capture aspects of numbing in documenting odd and vague recall of rape details, estrangement from loved ones, absence of pleasure, pessimism, and loss of all hope.

The Treatment of Emotional Traumata After Rape

The first two case examples raise questions about the various approaches to the treatment of rape victims in general and the importance of the numbing symptom in particular. The best therapeutic response for the emotional short- and long-term consequences of this worldwide epidemic of sexual trauma remains doubtful and even controversial. For example, even the benefit of immediate "debriefing" after a rape is uncertain since it may produce retraumatization (Barbosa, 2005; Gist & Devilly, 2002). Regarding the severity of rape trauma after effects: A community study of crime victims (Kilpatrick, Acierno, Resick et al, 1997) demonstrated that after nine years the group of 100 women who had been raped made suicide attempts (19.2%) than other groups. The rates were comparable to those of combat veterans with PTSD (Hendin & Haas, 1984). Studies of combat veterans with PTSD find that numbing often predicts an increased incidence of future anxiety and psychotic disorders (Kashdan et al, 2006) and chronic PTSD (Marshall, Turner, Lewis-Fernandez et al, 2006;).

Careful assessment of medication and treatment efforts for the entire post trauma spectrum of symptoms characterizing PTSD found that there was sufficient scientific evidence only for the efficacy of Prolonged Exposure Therapy ([PET] National Academy of Sciences, 2008). Cognitive-behavioral Therapy (CBT) more recently has displayed effectiveness in treating PTSD. There are excellent guides to techniques for PET and CBT for PTSD in general by Taylor (2006) and Foa, Keane, and Friedman (2009). There is also a comprehensive book by Foa and Rothsbaum (1998) about rape treatment with detailed instructions and techniques for therapeutic interventions. Several of their described patients did have numbing sensations and even some perceptual distortions similar to those that were

depicted in my Case example I. But more serious symptoms implying alterations in the sense of self, like depersonalization or derealization as found in my Case example II were not noted by these authors. This suggests that members of their study sample may have had less severe psychiatric disturbance than my first two patients. But numbing was often an important condition in this population, requiring special therapeutic intervention.

Numbing also has considerable predictive importance for specific treatment modalities (Foa, Cashman, Jaycox & Perry, 1995; Pietrzack, 2009). Nishith et al (2002) found that Exposure Therapy worked better to reduce avoidance than it did to ameliorate numbing. Numbing seemed to be more associated with major depression syndromes than did avoidance, and it (numbing) implied a worse long-term prognosis. This symptom, affect or condition is almost ignored in the largest research study of treatment of rape PTSD treated with Prolonged Exposure Therapy (PET) or Cognitive Behavioral Therapy (CBT). Their research evaluated the outcome of intervention with 171 rape victims treated in a research setting (Nishith, Resnick, & Grifin, 2002). Major symptoms showed considerable amelioration of symptoms with both interventions when compared to thos in a "Minimal Attention" control group. I surmise that the symptom of numbing was was largely ignored because it may have characterized the large group of 63 subjects that dropped out of the research study. This sub-group of research participants was not assessed.

Numbing Considered Within a Psychodynamic Context

Judith Herman in her superb classic, *Trauma and Recovery* (1992) emphasized the use of both psychiatric research and psychodynamic depth understanding for trauma treatment. The treatment strategy approach toward the four patients described in this report is informed most overtly by her contributions. The psychoanalytic perspective appears to use the language of everyday experience more than the more abstract, abstruse words of Psychiatry's discourse. But then"what's in a name?" Most of us have shared the experience of a tooth's physical numbness from a trip to the dentist. If we have had surgical anesthesia our memories vary little, and dental patients can communicate readily about the experience. But the words, numbing or numbness have multiple meanings, definitions, and connotations many of which are related to the experience and aftermath of trauma. In psychiatry, subjectively regarded, our patients' numbness is captured by colloquial concrete adjectives such as "zombified," "spaced out,", stunned," "deadened," "lifeless", "empty". Emily Dickinson's poem

at the beginning of this paper conveys the deathlike condition of numbing with the beauty of poetry. By contrast, Keats, in his "Ode to a Nightingale," (1819) captures its idealized association with nature.

Objectively, the condition is described though abstract terms, such as "affect," "anhedonia." "depersonalization," "derealization," "dissociation," "blunting," "flattening," "aporia," "alexithymia" or even as a "defense against affect". But further conceptualization and clarification of emotional numbing is complex. Its definition encompasses a broad variety of feelings with multiple nuances, comparable to what the term, "white" can connote in the Japanese language or what it may mean in Herman Melville's analysis of "whiteness of the whale" in *Moby Dick* (1851). Numbness can imply an avoidance of the hyper-aroused acute state of a devastating flashbacks or the blurred awareness of diminished pain without euphoria that a sedative produces in a mind's grasp of physical injury. But the sensation may occupy totally the vast sphere of consciousness, quite unlike the perception of a conversion symptom of hysteria that is usually appears to be localized to a specific body part.

Numbing conceptualized while using only psychological constructs is most compatible with psychodynamic therapy. Freud (Breuer & Freud, 1895/1995) compared mental trauma to a wound inflicted not upon the body, but on the mind. He recognized that a profound traumatic experience could not be fully assimilated as it occurred and hypothesized that in the face of trauma an innate barrier against dangerous stimuli could be threatened with rupture. The mind could split in two, yielding an altered state of consciousness in which some events could become dissociated, unreal, and repressed. Later unconscious material could surge back against repression thereby generating anxiety, different symptoms (hyperarousal, avoidance, obsessions, numbing) and recurring nightmares. Freud's interest in dissociation soon was subordinated to his absorption with fantasy, repression, and the Oedipal complex. But Janet (1907) restated Freud and Breuer's insights by asserting that severe trauma could be managed only through the emergency mechanism of dissociation. Carl Jung, his student, a few years later explicated both favorable and damaging aspects of dissociation. Dissociation Disorders in 1980 were included in DSM-III, the same year that PTSD made its formal debut (McFadden 2012). Janet's contributions inspired the clinical insights of Van der Hart, Nijenhuis & Steele (2006).

It is valuable to contrast aftermaths of rape with prolonged numbing with those instances where it is transitory. Numbing in the first two case histories above was profound and persistent. I consider its essence to be a

primitive affect, split off from its ideational content. The genesis of this particular primitive affect is well expressed through the concept of "structural dissociation". Apparently healthy but vulnerable mental structures strongly inhibit agonizing affect, leaving a severely traumatized person, "numb, depersonalized, and avoidant of conflicted painful" feelings and sensations (Van der Hart, Nijenhuis, & Steele, 2006, p. 285).

The absence of ideation and memory of the traumatic incident can be encapsulated by the insight that "some early childhood memories are at the same time unremberable and unforgettable" (Frank & Muslim, 1967, p. 48). In the light of their formulation, a too severe trauma marked by later prolonged or refractory numbing generates a regression to a primary process ideational state that is pre-linguistic or even "unlinguistic" (my neologism). They name the process, "passive primal repression." Applied to pervasive numbing a rape victim is unable to recall cognitively or forget the trauma. Only the split off painful affect may remain. Such a deficit constitutes a profound challenge for repair, which patients can accomplish through only through sharing the heavy emotional burden of the trauma with a therapist (or with a unique loved one). During this process, capacities for self-care, self-comfort, and self-regulation require much monitoring and support.

RAPE VICTIMS WITH LESS VIRULENT PSYCHOPATHOLGY

For purposes of contrast and comparison I present two other treatment courses that describe far healthier psychiatric patients. Their PTSD symptoms include short-duration or moderate numbing sensations during their gradual, but progressive, recovery from a rape trauma. Their therapy may include transference interpretations, or other therapeutic "uncovering" activities as illustrated by the following two case examples demonstrate.

Case Example III

Connie is a 40-year-old, successful private detective in a good marriage for many years. When I met her both her mother and sisters were having major emotional and drug addiction crises, and they frequently sought out her help and interventions. She over identified with their distress. During her childhood her dictatorial father was physically abusive to female members of the family; it was severe enough to bring about his incarceration. When she began the psychotherapy, contemporary family turmoil was absorbing her attention excessively, diverting her focus from her job performance. She was late in completing projects and found it difficult to complete investigations. Clients found fault with her performance.

A decade earlier while serving in the U.S. Army in Iraq, she was raped by a male senior military officer. Another woman soldier was also assaulted (almost a quarter of female military veterans have been raped (Steinhauer, 2013), but their joint complaints to authorities elicited an inadequate legal response. Sensations of numbing, and fantasies during which she could escape magically from an unjust, hostile male-dominated world lasted only for a few days. She felt anger more than despair and felt supported by her intense friendship with the other woman who had been attacked. Deeply disappointed by the military system, she took the active step of soon resigning in protest.

In later civilian life Connie had bouts of depression and though she had nightmares and insomnia that made it hard for her to hold a job, numbing did not recur. At times she experiences some symptoms of sexual inhibition, but these subsided after she married a kind, loving man who was a judge. Working in a criminal assessment system, her husband was often required to provide compensation for injustice. With his support and her keen intellect, Connie retrained and obtained remunerative, creative employment.

Sometimes during treatment sessions she would protest small signs of some of my compulsive rigidities and insensitivity to the nuances of a feminist's challenges. There was a kernel of truth in her criticism, although its intensity might have been amplified by a mobilization of transference attitudes related to childhood images of her father or rage against her attacker, both authoritarian males.

After several years a major challenge to her stability suddenly emerged; she was assigned by her boss to investigate a crime in which she had to partner with a colleague, whose ethnicity was the same as and whose face resembled that of her attacker. In one therapy session she noted that his type of baldness reminded her of me. She had already firmly decided to resign from her position, and retrain for a different career. The obsessional intrusion and reliving of her past pain with her colleague was interpreted, and her excessive, frantic efforts to assist floundering family members were terminated through my urgent advice. She acquired the understanding that excess energy devoted to solving family-member problems might be connected with unwitting efforts to undo her traumatic experience many years earlier. Now fully aware of the transference meaning of working with this particular assigned partner, she surmounted this crisis with the help provided by insight psychotherapy.

She vigorously pursued legal remedies through the Veterans Adminis-

tration clinical administrative system for compensation that she deserved. Her career path took an upwards spiral.

Case Example IV

Betty is 49 years of age, an athletic police officer with a good career. She is conventionally attractive enough to work part-time as a clothing model. But her beauty and competence has not been sufficient to lead to prolonged relationships with men or a happy marriage. A violent assault probably contributed to this. At age 27 Betty was gang raped and sodomized by a group of intoxicated professional athletes, one of whom she had dated for several months. "I was horribly hurt, sad, disgusted but my spirit was not taken away. I was determined to survive, and continued to think about what happened and if I had been careless." Feelings of numbing in the form of unreality sensations, memory loss, and fainting spells lasted only a few months.

Although she had close ties both with her many siblings and her parents, with whom she shared devout Catholicism, she did not reveal the incident to anyone until 14 years later when she phoned the "hotline" of a local woman psychic. That same year she tried to tell her parents about the incident, but while "they suspected what had happened to me they didn't want to hear any details." However, she thinks her father was especially kind to her when he sensed "something awful was hurting in me."

Perhaps because the rape left her with shame and lowered self-esteem she married a sociopathic man for a few years with whom she participated in minor illegal frauds, and drug thefts from pharmacies and medical offices. The couple had a child who after a period of adolescent turmoil became a model citizen and achiever.

Decades after the rape she began a decade of psychotherapy with me, precipitated by her difficulty in having durable intimacy with a series of males. Betty's most recent involvement was with a former college hockey player notorious for on-ice fights. Although he later became a model father, he had a persistent wild streak that included promiscuous relationships outside of his several marriages. After his most recent divorce, he had multiple exploitative relationships with younger partners, including my patient. She terminated this self-defeating situation after she was able to understand that her attraction to him might be related to working through her rape experience decades earlier.

Later, she concluded that her attack when she was a young woman,

> . . . made me more compassionate and spiritual. I was determined that my

son would have a better life than I had had. So I became more self-protective and disciplined in spite of all of my personal and economic limitations.

Her therapy demonstrated that a past rape incident revived in the present can be interpreted, mourned, assimilated, and used as an emotional growth experience.

CONCLUSIONS

The psychic aftermaths of traumatic rape with profound numbing differ importantly from instances in which numbing is transitory. The subjects of Case Examples III and IV were healthier, more resilient persons with only minor numbing. Neither of the two women used illegal drugs or required the transitory protection of hospitalization. They survived the trauma of rape with a more benign prognosis and were able to resume a near-normal life. In their psychotherapy, depth psychological interpretations and uncovering procedures were both appropriate and helpful. But the women in Case Examples I and II required the non-interpreting supportive therapy promoted by J. A. Chu (2010A) because they manifested severe emotional symptoms of numbing, and had powerful proclivities toward psychic dissociation and regression. Both patients had prolonged episodes of addiction, and repeatedly required hospitalization. The symptom of numbing was profound and persistent. Its basic essence in such an instances I conceptualize as a primitive affect split away from its ideational content.

Its genesis is captured well by the concept of "structural dissociation." During later adulthood, seemingly healthy personality systems and structures become so endangered by primitive raw emotions that these must be extinguished leaving behind a chronic numb state (Vanderhart, Nijenhuis, &Steele, 2006) often with near psychotic depersonalization or derealization. The concomitant absence of ideation and memory can be psychoanalytically considered a form of "primal repression," (Frank & Muslim, 1967). Possibly a patient can construct a new interpretation of the event through the use of naming and language. The numbing affect or defense against other hyper-aroused affect may diminish with time. But amelioration of such a deficit requires prolonged sharing of the emotional remnants of this kind of severe trauma with a cautious empathic therapist.

Numbing and avoidance make it difficult for patients to trust a therapist and to profit from complex interpretations or scrutiny of pre-traumatic personality configurations and early memories. A therapist in the

face of severe "complex trauma" with a prolonged regressive response and persistent numbness may need simply to help the patient hold together and prevent further regression. Repeated life-threatening crises inevitably damage the capacity for introspection and looking deeply within. If a treating professional detects a terrifying primitive terror during diagnosis or treatment of the aftereffects of being raped, there may be a risk of psychotic deterioration. In such instances, a therapist needs to soothe and support, or prescribe medication. Past trauma memories and interpretations of revived memories should be avoided. After psychological stabilization, severe traumatic memories must be approached with utmost caution and respect.

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