My Mind or Yours: Disorganised Attachment in Psychotherapy

Ataya Reena Kanji

A dissertation submitted to AUT University in partial fulfilment of the requirements for the degree of Master of Psychotherapy

2023

Faculty of Health and Environmental Sciences

Department of Psychotherapy

Supervisor: Dr. Kerry L. Thomas-Anttila

Abstract

The current research explores the relational complexity of psychotherapeutic work with adult patients presenting with disorganised attachment. Where disorganised attachment patterns during infancy and childhood remain unresolved, sustained conflict at the level of the attachment system continues into adulthood. The emotional intimacy of being in a consistent therapeutic relationship often reactivates for the patient traumatic impressions of early pain, tumult, and terror. How can both parties in the therapeutic dyad *live inside* and *live through* the frightened, overwhelmed, dissociative, distrustful and non-relational aspects of the patient and their emotional self?

Engaging in a hermeneutic literature review, I embrace the inherent contradictions and perplexities in the literature while listening to my subjective experience. I have applied clinical material, and my lived experience of disorganised attachment, to reflect on and analyse the strong transference/countertransference emotions and/or therapeutic dilemmas and enactments that characterise psychotherapy with disorganised attachment.

What shines through is a discussion on questions of separateness and relatedness, and what happens in psychotherapy when the capacity for mutuality and intersubjectivity is limited or disturbed. The current research suggests that for patients to *feel felt* and for psychotherapy to progress, therapists must allow the unmanaged and unmanageable parts of the patient's inner experience to exist within their mental field, which can evoke deep and complicated feelings of shame, powerlessness and helplessness. To be with patients and listen to them is to enter a new constellation of experience within the therapist's self (Lewin & Schulz, 1992). Future research may re-examine the relational complexity of psychotherapy with disorganised attachment from cultural, socio-political, intersectional or systemic approaches.

Table of Contents

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: Ataya Reena Kanji

Dated: 25th May 2023

Acknowledgments

My gratitude to my dissertation supervisor, Dr. Kerry L. Thomas-Anttila, for her continued patience and trust in my capability, and what I have further learnt about grace in letting a process reveal itself.

I also thank my psychotherapist, N., without whom I would have never been able to understand how much of me was in emotional need. I will continue living into your dedication to our therapeutic work.

Finally, I lovingly thank my family – my father, Giresh, my mother Sathna, my siblings Keelan and Jessica, and my living grandparents, Laxmi-ma, Bhula-dada and Sita-ma. There are untold ways to be on Earth and to be a human being, and I am grateful to be a cherished part of your lives. May we continue finding our way to each other.

Chapter 1: Introduction

During this study, I explore the relational complexity of psychotherapy with adult disorganised attachment patterns. I have chosen a hermeneutic literature review as my method; encouraging the contextualised, subjective experience of the researcher encountering themselves in the data, while remaining dedicated to textual exploration and analysis which can illuminate wider, and perhaps unobserved or disremembered dimensions of human experience (Crowther et al., 2017).

The inception of this dissertation began some time ago when I came across David Wallin's (2007) book *Attachment in Psychotherapy*, and particularly the chapter "The unresolved patient". Reading about the profound complexity that disorganised clients have in experiencing a secure therapeutic relationship was like a flare going up in the dark. Startling and revealing, it quickly became personal – or always was. I could begin to frame the chaotic and trying emotions that repeatedly bled into my own experience of personal therapy, as I had struggled year after year to place myself within a context that did not need me to be so frightened and abandoning of my emotional self.

During my training, I wrote in one of my academic essays: "I have cycled from positioning myself as having a narcissistic or borderline personality structure, to childhood post-traumatic stress, towards finding a meaningful understanding of myself as relating through a disorganised, or unresolved attachment style" (Kanji, 2021, p. 3). I argue that situating the current study within the field of attachment offers a less stigmatising perspective on psychological distress than many formal diagnostic criteria and theories of personality disorders. While disorganised attachment has been associated with dissociative, borderline and psychotic symptomology, and can be useful in understanding these presentations (Liotti, 2012; Siegel, 2012), it works less as a definition but more as a base from which to explore the particularities of each patient's presentation. My motivation for this research is both organic and deeply personal. I have found a softer perspective towards my own suffering – however, the question remains – how do I make sense of the relational complexity of attachment disorganisation, as a psychotherapist, as a patient in psychotherapy, and as a living and loving human being?

Disorganised Attachment and Relational Complexity: A Primer

Wallin (2007) argued that it is the internal security created during repeated therapeutic interactions which provides a context for change and transformation, as the attuned therapist helps the patient bear, articulate, and make sense of painful emotions. However, where individuals suffer from the internal amplification of shame and self-disgust, and believe themselves unlovable, they can hold distorted views of themselves and others (Herman, 2012). Safety and trust within relationships can

easily dissolve. The paradox defining the therapeutic situation is the great difficulty the patient has in bearing a secure relationship with a present and empathetic therapist, when the experience of being able to feel a modicum of safety with another person seems to be a precondition to confronting the long-held and often buried traumatic experience (Wallin, 2007). My desire to further explore this paradox led me to the following research question: how does the psychotherapeutic literature help us understand the relational complexity of psychotherapy with adult patients presenting with disorganised attachment patterns?

Locating the Current Study: Thinking Attachment, Psychodynamics and Psychoanalysis

The current study is anchored in the field of attachment because of its use of the concept of disorganised attachment. John Bowlby (2005) initially formulated attachment theory by following his conviction that humans, much like other mammals, are born with an innate tendency to seek care, help and comfort from others when experiencing physical and or emotional distress. He argued that humans' attachment bonds characterise human behaviour from the "cradle to the grave" (Bowlby, 2005, p. 154). Bowlby trained and worked as a psychoanalyst, and his ideas about attachment in the late 1950's and early 1960's had psychoanalytic origins; yet they were met with derision by important figures in the psychoanalytic community (Steele & Steele, 1998). Bowlby rejected the use of models of adult pathology to assess child development, and focused on the real, observable social interactions between people, both of which diverged from the psychoanalytic emphasis on intra-psychic conflict (Bretherton, 1998; Steele & Steele, 1998). For Bowlby, the distress of a child related to attachment, such as a fear of being abandoned, was likely related to the child being challenged with actual abandonment, rather than being a creation of their internal fantasies (Steele & Steele, 1998).

However, it is the "nonverbal and unconscious" (Schore, 2003, p. 72) core of the self which is affected in disorganised attachment, and where psychoanalytic and psychodynamic thinking provides texture to explore individual and relational adaptations borne out of early trauma. Psychoanalytic writers such as Melanie Klein enrich our understanding of disorganised attachment through theories which perceive and describe the possibility of the first year of life being a terrifying experience (Steele & Steele, 1998). There is a sensitivity "to the chaotic possibilities within the child's mind" (Steele & Steele, 1998, p. 102), curious to their wavering between worlds of fantasy and worlds of reality (Klein, 1932). It seems to be no accident that Klein supervised Bowlby, until he made a meaningful break from her theoretical influence (Steele & Steele, 1998). The current study seeks to acknowledge the influence of the real experience of the infant and the child with their

caregivers, and the presence of our inner psychological adaptions, coping strategies, unconscious fantasies and desires most abundantly explored in psychoanalytic and psychodynamic theory. These internalisations of early experience tend to regulate the ways in which individuals can show up in relationship later in life.

Literature review

Attachment

Attachment has been conceptualised as a system in the brain which affects and organises motivational, emotional and memory processes regarding important caregiving figures (Siegel, 2012). It guides the infant to seek physical proximity to the parent for survival, to be protected from harm and for emotional nurturance (Siegel, 2012).

Attachment is also a "regulatory theory" (Schore, 2003 p. 61), as the caregiver's matured brain directly assists the infant to organise the internal processes of their immature brain (Siegel, 2012). Attachment relationships are the primary environmental factors in early life which influence brain development during its greatest period of growth (Siegel, 2012). Where the caregiver can repeatedly and reliably synchronise and resonate with the rhythm of the infant's changing emotional states, the infant learns how to regulate their own emotional arousal and inner processes (Schore, 2003; Siegel, 2012).

The attuned caregiver serves as a reassuring presence when unpleasant and uncomfortable emotions are felt, and supports to enhance the child's experience of positive emotions such as in play (Schore, 2003; Siegel, 2012). These implicit memories of being met in relationship can contribute to secure attachment patterns and the internal presence of what Bowlby (2005) termed a "secure base" (p. 157). Individuals hold an impression of resilience and felt knowledge that they can adjust and make sense of their emotions and/or somatic sensations either on their own, or in relationship with another person (Schore, 2003).

Attachment Patterns

Our general ways of relating to others, or **attachment patterns**, are commonly categorised as secure or insecure (Siegel, 2012). Insecure attachment can be further characterised as reflecting either avoidant, anxious, or disorganised attachment behaviours (Siegel, 2012). These behaviours can consist of organised strategies (avoidant and anxious) or disorganised (disorganised) adaptions to early caregiver communication. These ways of coping, imprinted from our earliest years, regulate the flow of relational "energy and information" (Siegel, 2012, p. 95) in the brain, and can persist into significant relationships during adulthood.

Origins of Disorganised Attachment

The term **disorganisation** was first referenced by Main et al. in 1985, to describe the disorientated behaviour of infants seemingly caught between impulses to approach and avoid their caregivers during the Strange Situation procedure. During reunion with the parent, the infant might go toward, and then away from the parent, turn in circles, enter confused states of 'frozenness' or stillness, or cling onto the parent while leaning away and having an averted gaze (Main & Solomon, 1990, as cited in Siegel, 2012). Importantly, this behaviour was observed to be temporary, and infant's routine patterns of relating were generally associated with one of the other categories of attachment (anxious, avoidant, or secure) (Siegel, 2012).

When distressed infants are met with sudden fearful or angry reactions from their caregivers, they can defensively withdraw; and, for self-protection, minimise visible expressions of need for the caregiver (Liotti, 2004; Schore, 2010). This further activates the attachment system because the increased relational distance amplifies the infant's need for protection and closeness (Liotti, 2004). If the infant is left with their distress for a prolonged period without an available caregiver, they can enter states of overarousal, with high activation of their sympathetic nervous system (fight-or-flight) and/or parasympathetic nervous system (shutdown, dissociative reactions) (Poole Heller, 2019). Siegel (2012) described the phenomena of "developmental overpruning" (p. 113), where the release of stress hormones in the fledgling brain can lead to the disproportionate death of neurons involved in the neocortex and limbic system – regions related to emotional regulation. Traumatic stress in childhood can lead to a predisposition towards clinical dissociation, where "consciousness, states of mind and information processing become fragmented" (Siegel, 2012, p. 135). This non-verbal response directs attention away from internal states when painful emotions arise (Schore, 2010).

Siegel (2012) posited that disorganised attachment contradicts natural attachment tendencies which motivate infants and children to desire closeness to caregivers. It has been theorised as a response to an unsolvable internal conflict, where there is no coherent behavioural strategy which can resolve the bind of infants being dependant on care from the same caregiver(s) that threaten "bodily and/or psychic integrity" (Blizard, 2001, p. 40). Infants presenting with disorganised attachment were found to have caregivers who had their own unresolved trauma and losses and/or parented from states of mind characterised by fright, dissociation, aggression or helplessness (Liotti, 2011). These environmental circumstances can range from the infant being vulnerable to an emotionally unpredictable or neglectful parent, or someone who is "frightening too much of the time" (Poole Heller, 2019, p. 230), to boundary violations such as physical, emotional or

sexual abuse (Siegel, 2012). Herman (2012) argued that attachment disorganisation flourishes in an environment where the child feels torn between their need for emotional attunement and fear of rejection or humiliation. The child forms an internal sense of shame around their basic needs (Herman, 2012). These circumstances can also be heightened by the stress of birth and racial trauma, devastating life events, serious medical procedures and difficult socioeconomic conditions (Poole Heller, 2019; Siegel, 2012).

Adult Disorganised Attachment

Adult disorganised attachment tends to present as relational behaviours associated with avoidant or anxious attachment. Disorganised responses mostly occur under situations of severe stress or relational conflict (Poole-Heller, 2019). It can also be viewed as a regulatory condition, as the individual's ability to self-regulate is compromised (Degangi, 2012). Degangi (2012) describes criteria for regulatory disorders as including issues with sleeping and eating, intense states of irritability and distress, poor self-calming abilities, cognitive disorganisation, attentional and motivational issues and problems with emotional regulation which may present in bipolar disorder, depression, and or anxiety. When activated by a real or perceived threat, the individual with disorganised attachment can find their autonomic nervous system rapidly cycling between sympathetic and parasympathetic arousal, which can lead to severe fluctuations in temperature, eating or overeating behaviours, excessive or minimal sexual interest, fainting, and/or the immobility of a freeze response (Poole-Heller, 2019). Schore (2003) argued it is the propensity towards dissociation which can be most debilitating, where individuals are "not only detached from the environment, but also from the self – their body, their actions, and their sense of identity" (p. 38).

Significance of the Research

The trauma inherent in disorganised attachment can shatter "the boundaries we draw between inner and outer, self and other … my mind from yours, internal from external" (Wingfield Schwartz, 2012, p. 174). These are biologically and psychologically stressful experiences which may present as terrifying, enigmatic, and incomprehensible from the inside, and to onlookers (Herman, 2012). The current research seeks to provide important insight on the relational complexities that might be encountered for both patient and therapist during the treatment of adult disorganised attachment. This work has clinical application for psychotherapists and other healthcare practitioners in mental health practice, as well as services that provide mental health care for those with disorganised attachment patterns.

I also seek to explore possibilities for effective treatment, which is significant considering how debilitating disorganised patterns of relating can be for individuals looking to form intimate attachments necessary for emotional growth, well-being and healing (Schore, 2010). I want to look at what society may otherwise try to avoid; even if when I look at the effects of early relational trauma, they change shape. By bringing together psychoanalytic, psychodynamic ideas and perspectives on relational dynamics and attachment, I hope to extend the "clinical promise" (Wallin, 2007, xii) of attachment theory by deepening the understanding of relational complexity in clinical work with disorganised attachment.

Terms

I will generally use the word patient to describe individuals in psychotherapeutic treatment. First used in the 14th century, the word patient is derived from the Latin *patiens*, from present participle of *pati* to suffer, to mean "one who is suffering" (Merriam-Webster, n.d.). I argue that the word patient more fully embodies the responsibility of psychotherapy compared to the word client, which can reference individuals as customers or consumers. The word patient also acknowledges the role of psychotherapists as being part of a historical legacy of healthcare workers.

Exclusions

The current study focuses on psychodynamic, psychoanalytic and attachment literature to limit the scope of the study and keep it relevant to my current development as a psychotherapist. While I may reflect on infant and childhood experience for a holistic understanding, I will be excluding studies which pertain to clinical work with infants, children, and families or couples.

Chapter 2: Methodology and Method

During this chapter, I will orientate the reader towards the methodology and method of this dissertation. I have chosen to work within a qualitative paradigm because I am seeking to engage in an open-ended, descriptive exploration of the literature (Grant & Giddings, 2002), to gain an understanding of the relational complexity of psychotherapeutic work with adult disorganised attachment. Having selected a hermeneutic methodology, and using a hermeneutic literature review as my method, the investigation considers my subjective experience of engaging with the literature, while situating the research within a broader, "dynamic, non-linear process of striving for understanding of what it means to be human" (Schuster, 2013, p. 198). I will touch on the origins of hermeneutics and the development of philosophical hermeneutics, as they inform and inspire the direction(s) of this exploration. Hermeneutics asks the researcher to consider their positionality in the research, and I will take stock of some of my fore-meanings, fore-understandings and prejudices. I will also explore relationships between hermeneutical thought and ethical views around being in dialogue with trauma, through the work of Orange (2011, 2015), Nguyen (2011, 2012), Hoskins (2010), and Levinasian ethics (1969, 1990).

Hermeneutic Origins

The ancient Greek term *hermeneuein,* along with its Latin counterpart *interpretari*, references the understanding of divine messages and inner thoughts and their translation from our being, experiences, thoughts and mind into language (Zimmermann, 2015). Hermeneutics began to involve the interpretation and awakening of unfamiliar or obscured meaning in biblical scholarship, before turning towards examination of ancient and classical cultures, and then taking a philosophical turn with the growth of German romanticism and idealism (George, 2020; Zimmerman, 2015).

Augustine's influence on modern hermeneutics was his claim that interpretation of Scripture involved a profound and experiential level of self-understanding – moving beyond traditional, rigid interpretations of the Bible to the idea that each reader can make the truths of text their own (George, 2020). It was Friedrich Schleiermacher [1768—1834] who initially articulated the prospect of a more universal hermeneutics concerned with *understanding how we understand* what we encounter (George, 2020). Every striking artistic, scientific, or religious insight could only be known through the particulars of language and a person's life context, while offering partial vision into a "shared cosmic whole" (Zimmerman, 2015, p. 26). Martin Heidegger [1889—1976] departed from Schleiermacher in his thinking. He claimed that understanding is not a conscious, effortful endeavour, but instead *something we are.* Being unconscious and pre-reflective, understanding is

revealed through the ways we negotiate and orientate ourselves within the background of meanings into which we are born (George, 2020; Zimmerman, 2015).

With the publication of Gadamer's (1960) *Truth and Method*, philosophical hermeneutics transitioned into its own discipline (Zimmermann, 2015). Gadamer (2013) argued that each of us has a world inside ourselves, "already organised in its basic relations" (p. 14), affecting the way we encounter and make sense of each other. Learning through understanding, therefore, involves *mediation* of the perspectives we hold with those which are unfamiliar to us (Zimmerman, 2015). The same text can speak differently for the same person at different times, as our own mental constructs evolve and change (Zimmerman, 2015). Gadamer (2013) was also concerned with *how* we engage in the interpretative task, promoting an attitude of openness and humility to allow for a sense of growing mental possibilities (Zimmerman, 2015).

Epistemology and Methodology

This research is nestled within the epistemology of interpretivism, asking questions about human experience where "we work out many perspectives – many lexicons – and thus reveal many things as they are in themselves" (Dreyfus, 1991, as cited in Pernecky, 2016, p. 98). No single perspective can herald the discovery of truth (Pernecky, 2016). I initially considered a heuristic approach because of my personal identification with disorganised attachment, and the prospect of an internal journey of discovery. However, I recognised that the immersive nature of heuristics may have been mentally challenging for me during a time of personal change and transition. I also felt drawn to the idea of hermeneutics experience as *education* (Zimmerman, 2015), participating in the production of a fuller context of existing meaning and learning. It feels practical and useful to be adding to the literature on disorganised attachment. A relatively new concept, it is often misunderstood, avoided or omitted from discussions of attachment in popular self-development resources.

A hermeneutic approach also acknowledges the subjectivity of the researcher as both a precondition for interpretation and as a constraint or limit; therefore, it becomes required of me to examine, reflect on and explicitly state my own position(s) in reference to the inquiry before me (Grant & Giddings, 2002; Schuster, 2013). The study of psychological trauma involves contending with troubling societal dynamics which often "discredit the victim or render her invisible" (Herman, 1992, p. 22). Therefore, it feels appropriate to step away from the positivist viewpoint that knowledge is to be discovered so we can "explain, predict or control" (Grant & Giddings, 2002, p. 14) people, events or outcomes. Thus, research becomes an interactive and intersubjective process, shaped by personal history, gender, social class, race, ethnicity and other meaningful affinities (Koch, 1998).

Being in Context: Fore-meanings, Fore-understandings, and Prejudices

Our internal structures of thinking, being and attuning sculpt the way we interpret texts. These can be described as fore-meanings, fore-understandings or prejudices (Schuster, 2013). Gadamer's (1976/1977) expression of prejudices is not necessarily to suggest a narrow perspective; rather to emphasise the biases which limit our capacity for openness and experience. Here, I intend to shed some light upon the ways my own identifications and positionality may augment the current research – as someone who lives with and tends to my own disorganised attachment, and as tau iwi | new bones within Aotearoa, a (relatively) young woman of Gujarati heritage.

My supervisor and I have considered how I can maintain clarity given the ways my history, personality and attachment characteristics will stamp this research, just as they influence my clinical work with patients (Orange, 1994). The complications I have encountered, both in relationship with myself and with others, have felt terrifying, challenging, and at turns, shameful. I have been a person wondering how to feel safe in the emotional presence of another human being for many more years than I have been a psychotherapist. Perhaps there is something in being *self-conscious* as the hermeneutical attitude suggests, acknowledging where the researcher may feel deeply, and working mindfully with the firmness of these opinions (Orange, 2011). The existing literature is predominately authored by therapists exploring their clinical experiences with patients relating from disorganised attachment patterns. The current research will emphasise these perspectives, with an "inner ear attuned" (Zimmerman, 2015, p. 53) to my own personal emotional responses.

I also acknowledge that the psychotherapeutic literature I have accessed has long been slanted towards cultural reductionism (Ahmad, 1993, as cited in Moodley & Palmer, 2006). While a thorough investigation of how racial, ethnic and cultural identities contribute to the relational complexity of clinical work with disorganised attachment is beyond the scope of this research, I espouse, following the work of Bryant-Davis (2019), that trauma recovery care "must attend to the multiple layers of identity within each person" (p. 400). Psychoanalysis was established on the premise that each of us are "*other* to the conscious and deliberate self" (Rozmarin, 2007, p. 327), but it has often failed to nuance the realities of approaching the racial *other* in psychotherapy, such as "power, privilege, social injustice, social identity, immigration, skin colour, spirituality, gender, and therapist shame and guilt" (Bryant-Davis, 2019, p. 403). There is some comfort in recalling Gaztambide's (2015) thesis that the history of psychoanalysis is rooted in the experience of Jewish individuals who were marginalised and perhaps yet yields possibilities for social justice.

Schuster (2013) contended that the concern of the hermeneut is to recognise how their prejudices can lead to unreflective or even violent analysis, where I see what I want to see without

authentically engaging the text(s), without engaging the person before me or the cultural *other* inside of me. During instances where the therapist's race and ethnicity is rendered unimportant by a patient, the therapist holds two concurrent and challenging processes — to remain therapeutically available and receptive to the patient's material, while being aware of their own internal process and emotional responses (Dhillon-Stevens, 2011). One really needs to question what is happening in the quality of contact if parts of ourselves need to be sharpened off (Dhillon- Stevens, 2011). During my dissertation process, I take alongside me several things: what my Gujarati grandparents chose to preserve with each of their decisions, grasping an "imaginary ethnic culture from their "homeland" (Hussain, 2019, p. 4); the rage that Dhillon-Stevens (2011) speaks of within psychotherapy trainees belonging to black and minority ethnic groups; and the torn-ness of wanting to experience myself as free, but also belong to a specific cultural past unreachable in many ways (Moodley & Palmer, 2006).

Method and Research Design

The chosen research method of the hermeneutic literature review is a process "open ended and circular in nature" (Boell & Cecez-Kecmanovic, 2010, p. 132). The conventional elements of a literature review, such as formulating the research question(s); searching for literature; reading; mapping and classifying; critically assessing texts; and developing arguments, are made dynamic in the hermeneutic approach suggested by Boell and Cecez-Kecmanovic (2014).

I began the process conducting an online literature search of the Auckland University of Technology library databases using the search terms: "disorganised attachment", "unresolved attachment" and "disorganised attachment psychotherapy". Databases included PEP-web and PsycINFO. These searches yielded around 12 books and 1000 research articles. Being a small literature review, it would not have been appropriate to assess the entirety of the search results for relevance. I sifted through the first 50 results for research articles, and most were excluded as they pertained to investigations of disorganised attachment within infants and children.

In my book search results, I came across the 2012 book *Shattered States: Disorganised Attachment and Its Repair* edited by Judy Yellin and Kate White, and the 2010 book *Relational Trauma in Infancy: Psychoanalytic, Attachment and Neuropsychological Contributions to Parent-Infant Psychotherapy* edited by Tessa Baradon. Both books assisted me to identify practitioners and researchers with an active interest in understanding traumatism through theories of attachment disorganisation. I began to go beyond database searches by identifying potential sources through citation tracking, also referred to as snowballing (Boell & Cecez-Kecmanovic, 2014). Paying attention to the literature cited by others is a suggested way to identify additional material, however this is limited because it can only go backwards in time to pinpoint literature published before the original

text (Boell & Cecez-Kecmanovic, 2014). Upon identifying a relevant article or book, I would undertake a close reading, which involved reading texts on my laptop and copying any information that felt important for the overall process to a separate word document. During this process, I would highlight in different colours segments of text that I felt were meaningful for my research so I could easily return to them later.

I initially planned on exploring my research question through the neurobiology of attachment, encouraged by the work of Daniel Siegel (2012) and Allan Schore (2003, 2010). However, as the process deepened, I was intuitively relating the articles and literature I was reading to the psychoanalytic and psychodynamic theories I had found significant during my psychotherapy training. In Schleiermacher's hermeneutic circle of understanding, deliberate and repeated return from the whole to the parts and vice-versa *expands* the circle, where the integration of material into larger contexts "always affects the understanding of the individual part" (Gadamer, 2013, p. 174). It dawned on me that the neurobiological interpretation of attachment did not wholly sustain my research imagination, and I revised the scope of my research to integrate psychoanalytic and psychodynamic theories alongside perspectives on attachment. As suggested by Boell and Cecez-Kecmanovic (2014), the process of the hermeneutic literature review is non-linear. The hermeneut returns to any location in the research process as needed, to gradually develop understanding of the research question and material (Boell & Cecez-Kecmanovic, 2014).

Schuster (2013) described hermeneutic research as an "embodied activity" (p. 203) that moves beyond an attitude towards a way of existing in the world. It took time for the practices of assembling texts, undertaking close readings, and making interpretations to start feeling more deliberate. Making the decision to structure my findings using clinical material from published case studies, I felt ready to leave the hermeneutic circle of searching for literature and to start analysing and developing arguments. I had reached saturation in finding articles that only marginally increased my knowledge of the research area or came from familiar authors and/or perspectives (Boell & Cecez-Kecmanovic, 2014). For weeks I read and re-read the clinical material in the case studies written by Stramba-Badiale (2014) and Wingfield Schwartz (2012). I would wonder about the sense of the author's voice, perspective, and tone; their motives for writing about that particular therapeutic relationship; what parts of themselves or the patient seemed engaged or ignored; and what to make of their perspective of the relational complexity of the treatment. At times, I would write notes, brainstorm, or make bullet points to wonder about patterns in my research findings and what I may not be seeing or picking up on. I would go back and forth between the text in my highlighted documents and was often guided by my subjectivity to recognise what texts or parts of texts spoke to me and what the possible relationships were between them. I also sought to interpret

the literature in a broader way to confront something about the relational complexity of disorganised attachment that would be valuable to share with others (Schuster, 2013). My aim was to let the research process be less about what needs to be done, and more a continuous asking of "what is going on?" when I engage with the research question at large (Koch, 1998).

Ethics, Hermeneutics, and the Psychotherapeutic Encounter

The emotional "hospitality" (Orange, 2015, p. 37) of psychotherapeutic work echoes a moral, humanitarian responsibility. Staying with trauma means making "space for the patient in my own homeless heart, so that the devastated other may have a developmental second chance" (Orange, 2015, p. 37). For Emmanuel Levinas, who spent five years in Nazi prisoner of war camps and had members of his immediate family killed in the Second World War, the ethical relation with the Other is one with their transcendence (Orange, 2015). Levinas (1969, 1990) challenged us not to evade the suffering Other, while holding both the necessity and impossibility of a full ethical response. What is truly human remains "beyond human strength" (Levinas, 1990, p. 100).

Perhaps the real power of a hermeneutic consciousness is how it allows society to "see what is questionable" (Gadamer, 1976/1977, p. 13) in our commitment to trauma. Nguyen (2011) described both the societal fascination in her clinical work treating survivors of torture, and the public detachment in the assumption that "these people stand apart, they belong to a different category, move in a different emotional, moral, existential and clinical dimension" (Nguyen, 2011, p. 56). This ambivalence suggests the profound collective anxiety of a modern culture perhaps "increasingly dehumanizing, and dehumanized" (Nguyen, 2011, p. 30). Drawing upon Hoskins' (2010) thesis, entitled *Māori and Levinas: Kanohi ki te kanohi for an ethical politics*, I wonder about how dynamics in Western psychological thought have been underscored by motives for comprehensibility and authority. This is perhaps best substantiated by the push towards standardised means and medical diagnoses to contemplate suffering. I would argue that these narrow what can be experienced, known, and communicated around a person's reality (Nguyen, 2011). Levinas' argument that sense-making activities such as "systematising, classifying, pointing, even describing" (Orange, 2011, p. 47) are violent and can be murderous has particular poignancy in the context of his life history. This remains important when many of us, including psychotherapists, are drawn to easier and simpler explanations which avoid complexity and uncertainty (Gabbard, 2007).

Hoskins (2010) explored how kanohi ki te kanohi | face-to-face relations, are made possible from approaching others as *already inside* or *as relations*, customary in many Māori and Indigenous traditions, as opposed to being outside, comprehending or observing. Through kanohi ki te kanohi

"mana is manifested or animated, and such encounters can only be positively productive if the mana of the other is maintained" (Hoskins, 2010, p. 19). This intention and responsibility seems to allow something to become alive. No one purports to know in advance how the conversation will go, or what will happen, and how the task of hearing the other's voice might mean hearing what we do not want to hear (Orange, 2011).

Disorganised attachment patterns are "rooted in bodily experiences rather than in primarily mental processes, are so to say incarnated, bred in the bones of people" (Liotti, 2014, p. 324). I hear these words as a reminder that when we seek treatment in psychotherapy, we are reaching into our core. Trauma research, including my own dissertation, has power in defining "what it means to be human, what constitutes a good life, what desecrates it, and how we can restore it" (Nguyen, 2011, p. 29). Acknowledging the ethical and political choices I make with this research encourages me to endeavour to approach from being already inside, as relations, and informs my decision to use clinical case material to explore my research question in the next chapter. In attuning to lived experience to understand the literature, I hope to hold the relational struggle of disorganised attachment with sensitivity and humility.

Chapter 3: Findings

In this chapter, I use clinical material from two case studies to explore the relational complexities of psychotherapeutic work with adult patients presenting with disorganised attachment. In particular, I examine themes around vulnerability, powerlessness, fragmentation, and shame; as well as questions about intersubjectivity, attachment and relationality/anti-relationality. In Part 1, I focus on my close reading of Stramba-Badiale's (2014) article "Affective Attunement, Vulnerability, Empathy: The Analytic Experience with Veronica". In Part 2, I use my reading of Wingfield Schwartz's (2012) chapter in the book *Shattered States: Disorganised Attachment and its Repair*.

Part 1: Veronica

Psychic Vulnerability and the Wounding Healer

> At the same time, I sensed that the patient really needed to feel that I was on her side, and her frail sense of self came forth from the very first sessions, for she was always on edge, fearing possible retraumatizations. The patient was so worried that I might have difficulty in becoming attuned that I began to feel almost as if I were holding a vase made of very fine crystal that could shatter into pieces at any moment. (Stramba-Badiale, 2014, p. 281)

How do we bear the anxiety of past attachment trauma being experienced by our patients in the now, and as impending? How can the literature help us understand these relational complexities when working psychotherapeutically with disorganised attachment? The image of the precious vase shattering feels analogous to the psychological response of fragmentation when "facing the possibility of psychic or physical annihilation" (Yellin & White, 2012, p. xiv). For those with a history of chronic attachment trauma, the activation of the attachment system during a lengthy therapeutic relationship brings the possibility of re-experiencing the overwhelming helplessness and terror of the original attachment injury (Liotti, 2014).

While an empathetic stance may prevent some therapeutic ruptures, it cannot prevent attachment disorganisation from becoming palpable. The therapist's empathy may even make more likely the collapse of the strategies which the patient has used to protect themselves from emotional dysregulation such as internal control, caretaking for others or sexualising relationships (Liotti, 2014). Even interactions which appear neutral, like agreeing upon certain guidelines for the therapeutic setting, can cause distress at an implicit and emotional level for those living with disorganised attachment (Liotti, 2014). Reflecting on Veronica's deep anxiety and fear of not being attuned to, I found myself thinking of Winnicott's (1974) paper "Fear of Breakdown". Winnicott (1974) argued that the fear of re-traumatisation is *"the fear of a breakdown that has already been experienced"* (p. 103). Winnicott (1974) aptly named these fears "primitive agonies" (p. 103) and recognised them as being more severe then generalised anxiety. I wonder about what needs to be

experienced by patients in the therapeutic setting for these overwhelming sensations to become integrated as part of the individual's past, acknowledging that this may not be entirely possible. I circle back to Wallin's (2007) paradox: the patient's difficulty in tolerating a secure relationship with the therapist circumscribes much of the treatment of disorganised attachment. Stramba-Badiale (2014) described his impression that Veronica "really needed to feel that I was on her side" (p. 281) but creating a dynamic in which the patient "*can* actually feel safe is essential and difficult" (Wallin, 2007, p. 245).

However, in the moments when psychotherapists consciously or unconsciously fear causing harm to their patients, they are not free to work in and access their best analytic sovereignty (Benjamin, 2018). Clasping and gripping onto the fine crystal vase, the arrangement to provide therapeutic hospitality may leave therapists feeling like a "hostage" (Critchley, 2007, p. 60). Being in relation with the "Other" (Levinas, 1969, p. 203) is complex because they can put everything we have known to be true into question and introduce into me "what was not in me" (p. 203), just by virtue of existing. Levinas (1969) suggested that the ethical presence remains other and outside the Other but enacts itself without violence; perhaps relatable to Benjamin's (2018) proposal of a co-created "shared Third" (p. 49) — a space that acknowledges the need for both parties in the therapeutic dyad to affectively survive.

Bearing the gravity of what can be emotionally and relationally experienced when working with disorganised attachment seems to mean re-learning and finding the capacity for the absurdity that *"we may harm to heal"* (Benjamin, 2018, p. 49). It is one of the hardest lessons I have had to learn as a psychotherapist — that I may not only be a wounded healer, but also a "wounding healer" (Benjamin, 2018, p. 49). As Veronica's fear invites a re-infliction of the very wounds she is seeking to heal, we can glimpse the potency of the therapist trusting in the relational fluctuations of misattunement, disagreement and disconnection, and the likelihood that patients can and often do survive the lapses and failures of their therapists (Benjamin, 2018).

The "What" before the "Why"

> In the early months of the analysis, my often unsuccessful attempt to see things from her point of view led me to feel that I was dealing with something that was "too much:" too unbearable, too heavy, too hard. I sometimes doubted that analysis was really what she needed, and the analytic scene was dominated by my complete inability to meet Veronica's painful fragmentation. Wearing the attributes proposed by the patient during the sessions, which were all governed by the hypothesis that I was inevitably unable to take care of her, sometimes weighed upon me in an unbearable way. This made me see parts of myself that I could hardly recognize and filled me with feelings of shame and often powerlessness. (Stramba-Badiale, 2014, p. 281)

Powerlessness can be described as a "complex bodily feeling" (Liotti, 2014, p. 332) related to the somatic initiation of the dorsal vagal response and a process of hypoarousal. Where fighting against maltreating caregivers was unworkable and flight was not possible, dissociative mental processes that underlie a deep sense of helplessness may have been repeatedly activated. This can include a distressing sense of being detached from one's own body or consciousness, and a loss of self-possession or characteristic behaviour, all of which disturb an understanding of continuous self (Liotti, 2014). While these states are not usually amenable to intentional thought, consciousness or language, they can be mitigated by a feeling of connection within warm, compassionate social interaction (Liotti, 2014). However, in the context of disorganised attachment, the possibility of experiencing emotional intimacy with another person can be inhibited by defenses which preclude a sense of basic trust in oneself or others, including the involuntary survival strategies of dissociation and emotional dysregulation (Liotti, 2014; Schore, 2010).

The relational complexity of working with disorganised attachment seems to involve the therapist's feeling of impotence, which Stramba-Badiale (2014) describes as a persistent doubt that you are helping the patient in the best way. A psychotherapist who remains neutral and impassive may activate a patient's feelings of rage and powerlessness related to early emotional neglect, whereas if a therapist is expressive, timely and caring, it could feel superficial, infantilising, or produce fear in the patient (Liotti, 2014). It is worth reflecting that the seemingly desirable context of having one's needs, desires and vulnerabilities given commitment in therapy may not always feel compassionate (Celenza, 2007). It makes me reflect on the delicacy of a baby's need in their earliest days to have objects exist *just* at the right distance (Papousek & Papousek, 1978, as cited in Alvarez, 1993). Only when something is *just* at the right distance it becomes seeable, and the breast can be fed from in a nourishing way (Papousek & Papousek, 1978, as cited in Alvarez, 1993). There is a profound difficulty assimilating experience; particularly the experience of the "animate object" (Alvarez, 1993, p. 104) of another human being. I am curious about this particularity, and what makes it more, or less possible for us to be 'taken in' by patients when emotional closeness in the past may have been paired with abuse, neglect or disappointment (Liotti, 2014).

Stramba-Badiale's (2014) account of "wearing the attributes" (p. 281) given to him by Veronica seems to speak to the creativity of projective identification: "How is it possible that an unwanted bit of one person's psyche can lodge itself in the psyche of another? How does that bit get across the intervening space?" (Field, 1991, p. 94). Field (1991) suggested that when we enter relationship, we exist as human beings in a state of merger. Our connection remains central, and any sense of separation or differentiation from one another is illusory, maintained by a set of defences: "What happens to one happens to the other" (Field, 1991, p. 97). It speaks to the way patients may

call upon their therapists to revisit their own primal, existential, and internal griefs (Slavin & Kriegman, 1998). The therapist's experience of feeling considerably strained and affected can be critical for the treatment (Alvarez, 1992). As Symington (1996) suggests, it may be that when the therapist is able to make an inner emotional move that the patient is able to do so too. However, Jung (1985) suggested that the yoke of the patient's unconscious and tempestuous contents weigh heaviest inside them, and when activated, can isolate the patient in a "spiritual loneliness" (p. 240). This cannot be fully comprehended, by themselves or others, and so is certain to be misunderstood (Jung, 1985).

Following Alvarez (1993), I wonder if the way an experience can only be digested and understood when it is located in someone else may be more about "questions of perspective, than questions of projection" (p. 106). The *"what"* of Veronica's emotional reality, of something "too unbearable, too heavy, too hard" (Stramba-Badiale, 2014, p. 281) enters the therapeutic encounter before the "why". The helplessness of Veronica's belief that her analyst will inevitably be unable to take care of her, as her parents were unable and as she has struggled to take effective care of herself, suggests that for Veronica to move towards integrating her own experience, "something may need to grow for the first time" (Alvarez, 1993, p. 121). There is a missed experience of engaged and alive interaction with a consistent caregiver (Alvarez, 1993). What does it mean, and is it possible, for therapists to provide clients like Veronica the psychological soil from which to develop?

Attachment, Intersubjectivity, and Enactment

> Together we build a model scene in which the mother leaves the little girl alone in front of the TV set to go and play cards with her friends, and when she comes back late at night she finds the child exhausted from all the screaming and crying. We formulate the hypothesis that, for the patient, feeling alone elicits the unbearable sensation of something irreparable, like an abyss she can only sink in. Significant in this regard is the enactment that took place during one session, when, on account of a short delay on my part (she had sat in the waiting room of my office as I finished making a phone call), she began sobbing inconsolably. When I admitted I was responsible for the empathic rupture, Veronica withdrew into a heavy silence that lasted for the rest of the session. During the following session, we reconstructed this episode as a strenuous attempt to somehow influence the relationship with me. In any event, such an experience generated an embryonic sense of control and agency. (Stramba-Badiale, 2014, p. 283)

Veronica's experience of repeated and devastating disruption in her earliest attachment relationships seems to have contributed to an internal atmosphere where unintegrated affects (including implicit and pre-verbal memories) are re-lived within the therapeutic relationship in a way that feels "wordless, timeless and without context" (Wallin, 2007, p. 244). The hyperactivation of the disorganised attachment system contributes to relational complexity because it significantly reduces the capacity for intersubjectivity (Cortina & Liotti, 2010). Intersubjectivity encompasses social

understanding; altruism; cooperation; and mentalising, the ability to understand the intentions, emotions, and goals of others, and observe and reflect on one's inner experience (Bateman & Fonagy, 2004, as cited in Cortina & Liotti, 2010). A neurobiological theory for the inverse relationship between intersubjectivity and attachment suggests that during periods of traumatic stress, such as the overwhelming feelings of helplessness Veronica experienced as a child, some parts of the brain and peripheral nervous system are turned on while others are turned off (Cortina & Liotti, 2010). The activation of the attachment system kicks off a survival response in our soma, and we become foremost concerned with seeking protection for ourselves (Arnsten, 1998).

The breakdown of intersubjectivity and mentalising abilities is usually specific to relationships which can prompt traumatic memories and activate an already hyperaroused attachment system, such as the therapeutic relationship (Cortina & Liotti, 2010). The therapeutic rupture between Stramba-Badiale (2014) and his patient Veronica is an example of this. Being able to integrate attachment and intersubjectivity needs is a developmental challenge which greatly depends on the quality of the relationships between an infant and their caregiver(s), and the infant's safety to respond in their own autonomy and subjectivity (Cortina & Liotti, 2010). Benjamin (2018) argued that if intersubjectivity is to be grasped, the child must be involved in co-creating with their caregiver(s) a "mutual dynamic of reciprocal responsiveness and understanding" (p. 12). This can also be described as the position of the "the Third" (Benjamin, 2018, p. 13), where each individual in a relationship can recognise the other in a psychologically meaningful way, rather than as an object to be controlled, expended or pushed away (Benjamin, 2018).

However, Benjamin (2018) suggested the position of thirdness is bound to continually and habitually collapse into "twoness" (p. 39). This movement is described as a "kind of anti-play" (Benjamin, 1988, p. 63), where the pursuit for recognition becomes a power struggle and assertion can evolve into aggression. Stramba-Badiale (2014) and his patient Veronica are trying to live through Veronica's experience of herself as the little girl crying herself into exhaustion and the adult in rageful withdrawal, as well as further possible uncertain and fragmentary personalities (Schwartz, 2013). I would argue that most of these parts are desperate to avoid being abandoned. Klein (1932) proposed that the child needs to have the mother always be there so as to prove to them that she is not dead, and that "she is not the 'bad', attacking mother" (p. 248). While Klein is suggesting that the presence of the mother protects the child from their intra-psychic object of the 'bad' mother, this can also be figuratively applied to the therapeutic relationship. The patient with disorganised attachment patterns may always begin psychotherapy with the introject of the therapist being the 'bad', attacking mother. The real and continued presence of the therapist and their dedication to repair is paramount not only in proving that they are not *dead* or attacking, but that there may be

something relationally useful or nourishing enough to withstand inevitable periods of missing or absence, such Stramba-Badiale (2014) being late to Veronica's session because he was answering a phone call.

However, the defenses that disorganised clients use to avoid experiencing the painful emotions of their past often ends up recreating these upsetting feelings and situations in the present (Wallin, 2007). We get a glimpse of Stramba-Badiale's (2014) possible frustration through his interpretation that Veronica's reactions were motivated by her wanting to have power and/or influence the therapeutic relationship. These strong transferential and counter-transferential feelings can deeply impact the trajectory of the therapeutic relationship (Wallin, 2007).

I reflect on Benjamin's (2018) description of falling into twoness, where the therapist feels as if something is being *done* to them and may feel the need to defend themselves against the patient and their emotional reality. Sunk into the excruciating abyss of aloneness, Veronica appears to consciously and unconsciously pull the dyad into shame: *I must have been left because there is something is bad or wrong about me…* (Stramba-Badiale, 2014). What does it mean that the patient requires the therapist's willingness to stomach with them the "burden of badness" (Benjamin, 2018, p. 41), but may also require the therapist's refusal to go with them into certain emotional states such as helplessness or wrongness? (Slavin, 2005). The paradox of recognition posits that if we wholly negate the other, dominating and destroying them as we propel them into our feeling, we negate ourselves too as there is no one left to recognise us (Benjamin, 1988). I wonder about therapeutic engagement and curiousity with the multiplicity of Veronica's parts during the enactment, including those that may feel unacceptable, unwanted, controlling, powerless, anti-social, even sadistic (Schwartz, 2013). I would argue that what remains and seems to matter is the continual sense of losing and trying to recapture the intersubjective perspective (Benjamin, 2018). Stramba-Badiale's (2014) presence with complex, chaotic and undermining feelings and the continuation of the treatment even when experiencing doubt, seems to anchor something in Veronica. We hear that by the end of Veronica's analysis, the earned security in the therapeutic dyad has guided them to a universe where "we often remained in silence, even for several minutes. A silence, however, without loneliness" (Stramba-Badiale, 2014, p. 287).

Part 2: Ann

Meeting the Non-relational and Anti-relational

> Ann told me there was a child inside who desperately wanted to communicate with me, to be comforted and heard. She was ashamed and fearful of the fact that this child was "needy". She told me about a dream in which she was wandering in corridors and a slug appeared. The slug then switched into a cat and attacked and scratched her. "Slugs are

> intruders," she said, "and the cat looked a bit like your cat, actually". We discussed the fact that Ann felt anyone who got close to her would become "too close" and would intrude or betray her like her mother. Feeling that this had been something of a breakthrough, I found myself lulled into a false sense of security. I could feel myself in the countertransference floating on the ceiling, relaxed and looking down on myself. Then I "came to" and heard Ann saying she would have to stop coming to therapy in September. In fact, she was saying, psychotherapy was probably a load of rubbish. There was no needy child inside; she did not know where she had got that idea. I was aware in the countertransference that I felt she had suddenly turned on me. I reflected this back to her and said that she was doing to me what the slug and cat had done in her dream: she had found a way in and then attacked me. I wondered if Ann was doing this to me, rejecting me, because she was terrified I would do this to her. She wanted to get in there first. She agreed, and by the time she left we felt close again. (Wingfield Schwartz, 2012, p. 187)

The clinical work of Wingfield Schwartz (2012) with her client Ann allows us to explore how psychic processes associated with disorganised attachment contribute to relational complexity in psychotherapy. Where a child learns that they have to process and contain the intense emotions of life *"all by himself"* (Kalsched, 2020, p. 138), inner dissociative defences become necessary, and present a challenge to the therapist's task of helping clients reconnect to their unconscious emotions as conscious feelings. Ann communicates that there is a child inside, longing to be soothed and attended to, but also shares the fierce evocation of inner fear and shame for the presence of these needs (Wingfield Schwartz, 2012). One way of examining Ann's struggle is through Kalsched's (1996) theory of a mental "self-care system" (p. 4) arising out of early traumatic experience. This system is underdeveloped compared to a person's functioning ego and harbours an inner "Protector/Persecutor" (Kalsched, 1996, p. 5). This internal figure seeks to protect the traumatised residue of the person's spirit from re-injury, but at a high cost. The energy for these defensive and dissociative manoeuvres stem from aggression, involving active attack of one part of the mind on other parts (Kalsched, 1996).

The relational work of Wingfield Schwartz (2012) with Ann can be reimagined as grappling with Ann's powerful urge towards attachment and closeness, and an equally formidable internal force *against* life (Kalsched, 2020). During the dream that Ann shares with Wingfield Schwartz, the intruder of the slug, followed by the injurious cat that looks like the therapist's cat, could represent the presence of the Protector/Persecutor, imbuing Ann's mental image/feeling of her therapist and the process with the threat of betrayal and intrusion. The traumatised psyche is *"self-traumatising"* (Kalsched, 1996, p. 5). Part of the relational complexity of working with disorganised attachment is navigating repeated cycles of hope, vulnerability, fear, shame and self-attack which can result in depressive feelings. While the Protector/Persecutor can serve an extraordinary role in safeguarding personhood during early overwhelm, internal patterns of defending the psyche through fragmentation [dissociation], fantasy [schizoid withdrawal], numbing [addiction] or deep constraint of expression [depression] can begin to feel isolating and self-sabotaging (Kalsched, 1996).

The surfacing of the child inside Ann seems to be an experience of waking into emotional consciousness. Not only is the fear of reliving the devastation of the original trauma activated, but also the recognition of having continued on past it (Caruth, 1996). The parts desperate for emotional contact, both painstakingly shielded from others and fortified against, are finally now thinkable with another person. However, this seems to galvanise the violent energies of Ann's inner Protector/Persecutor who assaults her dependant and needy parts, and the therapy itself. For the individual wresting with dissociated trauma, the prospect of integration or moving towards coherence may not feel therapeutic, but distressing and awful (Kalsched, 1996). While therapists can ask patients to become more conscious and accountable for a relationship to their oppressive or destructive defenses in the therapy and their behaviour towards them, I agree with Kalsched (1996) that to hold patients responsible for this "resistance is a terrible mistake" (p. 26). Part of the relational complexity of working with disorganised attachment seems to be holding the presence of psychic discontinuity, multiplicity and divisions, and/or an inner Protector/Persecutor which can represent mental parts that are intensely non-relational or anti-relational.

The lack of relationality within the mind of the disorganised patient can be repeatedly felt, echoed, and sustained, in the therapeutic dynamic. How can we come to know more of the patient's whole self, given the presence of parts which may not be able to exist in relationship inside themselves, or with others? I am now looking to get to know, and appreciate, the parts of the patient trying to get themselves known through processes of action and enactment, alongside those more readily verbalised and organised (Benjamin, 2018; Grossmark, 2018). Benjamin (2018) described how shame-full these parts can be – feeling bad, destructive and alone. When these deeply shame-full parts are seen by the therapist, they may feel moved to empathetically manage the patient's affects with reassurance, or experience shame and guilt for not being able to re-regulate the patient; both of which may be unsuccessful in emotionally contacting the patient where they are (Benjamin, 2018).

Companioning patients through experiences of their regressed, shattered, and scattered self-states requires therapists to reflect on their capacity to be a whole person (Grossmark, 2018). What being a whole person really means is an individual question, but I consider the necessity of facing into our own unconscious needs, dissociation and dysregulation in response to the spectrum of aliveness our clients bring to us (Benjamin, 2018; Grossmark, 2018; Wallin, 2007). This includes our sensitive attachment experiences. I wonder what became activated for Wingfield Schwartz (2012) during the course of her therapy with Ann, and how painful it may have been to make herself available for continued rejection. I have a sensation of Wingfield Schwartz being alert to any changes, swerves and fluctuations in the intimacy of the therapeutic relationship, perhaps because Ann herself had been mostly unable to hold this relational anxiety. During periods where words become less useful,

unreliable or inert, it is the therapeutic relationship which becomes the most dependable therapeutic factor and the site of therapeutic action (Balint, 1979, Wallin, 2007). Considering the human responsiveness to nonverbal signals, it is not just what therapists say or do in the therapy that stirs the patient, but also therapists' inner emotional experience and attachment (or non-attachment) to their patients (Wallin, 2007).

Disorganised Attachment and the *Now* Moment

Understanding the significance of the present moment provides another perspective on the intricate dance of psychotherapy with disorganised patients. Both a crisis and an opportunity, these "*moments of meeting*" (Stern, 2004, p. 170) can implicitly reorganise the intersubjective field, opening up relational possibilities and allowing the therapeutic dyad to break new ground together (Stern, 2004). Such moments challenge the existing milieu of the therapeutic relationship, testing the therapist and the therapy (Stern, 2004). Perhaps these present moments can feel more urgent or frequent, or at least more vivid when working with disorganised attachment – the therapeutic relationship is with greater acuity the location where patients are unconsciously driven to create reverberations of their past trauma (Wallin, 2007). Individuals are often "embedded" (Wallin, 2007, p. 246) in their experience of emotions and feelings as being reality and carrying a "*lack of resolution*" (Wallin, 2007, p. 227) to earlier traumatic experiences. As such, therapist interpretations can be experienced as interfering, cruel, demanding, hostile, overly affectionate, or meaningless, despite the best of intentions (Balint, 1979). The therapist is so *continually* invited into the present with the patients to tolerate the regression in a shared experience (Balint, 1979).

Wingfield Schwartz (2012) described entering a calm state after what she feels is a breakthrough moment with her patient Ann, followed by a countertransference feeling of Ann "suddenly" (p. 187) turning on her. Both participants are propelled into the present and into the *now,* and everything else falls away. The relationship is again up for negotiation, following Ann's declaration of wanting to end the therapy. I am curious about the possibility that during Wingfield Schwartz's moment of calm, Ann could feel, however unconsciously, that Wingfield Schwartz was slightly dissociated and therefore unavailable in some way. Given Ann's vulnerability in that moment, it makes sense that this would inform her disparaging and dismissive response, therapy being a process happening between two people and not inside only one person (Balint, 1979). When Ann's fear of being abandoned by Wingfield Schwartz is reflected back to her, their intersubjective field changes to permit hope.

During the present moment, the patient and the therapist go through their own inner reorganisation in the presence of one another (Stern, 2004). Enigmatically and almost effortlessly,

parts of ourselves, familiar and unfamiliar, seem to presence themselves in the act of the therapeutic dyad meeting repeatedly over time. In spite of not actively sharing the content of my life, I do feel my patients have gotten to know me deeply, and this has great meaning for me. It is vulnerable to understand that both parties in the therapeutic relationship can feel it, however unconsciously, when the pain points of my attachment injuries have been hit. I understand and re-understand how intimate it is to1 be in a therapeutic relationship, and the anxiety created by a now moment, where we might be tempted to reduce the tension by operating from standard technique rather than responding from our fullest freedom and authenticity (Stern, 2004). Exploring different understandings around the relational complexities of working with disorganised attachment, it rings true for me that effective therapy may not always be about *doing* something to work through issues of separateness and relatedness, but more about the willingness to be alive when the moment calls for it – to go *with* and live through an experience together (Grossmark, 2018).

Eroticism, Love, and Shame

> By this stage in the therapy, Ann was able to recognize very quickly in the session that this was a response to the intense erotic feelings she had experienced in the room. All her life she had protected herself from ever falling in love, ever risking her love being unrequited. Now she had lost her defence, she feared that she would be utterly dysregulated. She felt it would destroy her, that her feelings were shameful, and that she could never be loved in return when she was so deeply disgusting and shameful inside. In near despair, I decided to write to Ann. I felt that unless I was willing to make myself vulnerable and exposed in the relationship, the inherent inequality Herman describes would leave Ann locked in shame forever. I wrote to Ann about my feelings that she deserved to be loved, that I did love her. I wrote about how desperately I wanted to reach her, to let her know she mattered, that she did not deserve to feel shame, and how I felt I was failing her by not reaching her. How I felt her mother was there with us, making us both feel ashamed and worthless, but that, nonetheless, this was not succeeding in preventing me from wanting to be close to Ann, and would never make me believe Ann was bad inside. She wrote back to me: "I seem to have been thinking all the time about (shame). I know this always comes up when I try to get closer to you and it acts as a block. I feel it's unbearable that I'm not allowed to have you. "It makes me feel like a sort of murderer. I keep resisting the word, but I have to accept it. I feel like the guard of a prison camp inside. Like my mother. Sometimes inside I get thoughts of abusing you or of getting you to abuse me, as a way to escape the deadness. But I know I'm unable to do that anymore, I've changed enough to know that doesn't work or release anything. I look at you and none of the past ways of trying to have relationships will help. I was proud not to feel and now I love you; you are linked to me now inside in a deep way. I guess I should understand it that I want to be alive, and I want you to be. Not for one of us to have to murder the other. Although that brings terrible shame it will have to be borne, and I will have to deny the rules and messages that I do not deserve it". (Wingfield Schwartz, 2012, p. 191)

The layered, reflective exchange between Wingfield Schwartz (2012) and her patient Ann allows for curiousity in exploring the complexity of love in the therapeutic setting when it is inextricably linked to pain. Given each individual brings to therapy the traumatic, unresolved, and internalised ways

they love and have been loved (Celenza, 2007), I will give weight to some reflections around sexual desire and sexuality, power relations and shame in therapeutic relationship with dynamics of disorganised attachment.

As Ann experiences erotic feelings in the therapy, sexual longing and the physical body become vehicles which place Ann in touch with her hunger for what has been relationally lost in her early life and adulthood (Atlas, 2016; Wingfield Schwartz, 2012). Atlas (2016) connected sexuality and the sexual act to emptiness and void, where the "tension of life and death, joy and pain, the known and the unknown, the full and the empty elements" (p. 28) are acutely held. Earlier circumventing any need of the body, mind and feeling which could incite experiences of helplessness, Ann's experience of adult erotic transference should be celebrated as part of working through the relational push-pull dynamic which underscores disorganised attachment (Wingfield Schwartz, 2012). However, Ann's embodied and articulated feelings of love also augment the sensation of arousal and exposure within the therapeutic dyad (Atlas, 2016; Wingfield Schwartz, 2012). Bataille (1954, 1957, as cited in Stein, 1998) described eroticism as a feeling of lack and searching for a way to experience continuous belonging to and merger with another, undoing us and giving us reprieve from our lonely individuality. However the presence of the other person inherently signifies discontinuity and disruption. It is a duality Ann seems to feel powerfully in her desire for intimacy and fear that she will be dysregulated and destroyed in loving and being loved, and perhaps what Stein (1998) alluded to in human sexuality creating more tension than is gratifying or even tolerable.

Celenza (2007) posited that the power asymmetry between therapist and patient has its own sexual tension which echoes the power imbalance we are born into within the parent-child relationship. She proposed that both parties will feel moved at various times to flatten the hierarchy of the power relations in therapy, given the multiple contradictions we ask ourselves and our patient's to hold in the therapeutic setting (Celenza, 2007). Wingfield Schwartz (2012) described feeling close to despair, acutely aware of the "inherent inequality" (p. 191) of the therapeutic relationship which she feared would stiffen Ann's inner experience of shame. It makes sense that therapists would feel internal discomfort in sustaining the contradictory promise of equality and mutuality "we are in this together", and unreciprocated emotional focus on the client, "you are in this alone" (Celenza, 2007). Celenza (2007) argued that therapists must withstand the guilt about having and/or wanting power, the difficulty of becoming their own authoritarian "bad object" (p. 293), and should resist gestures which promote an impracticable equality.

Celenza (2007) offered two perspectives for how therapists have power over their patients: they are more contained in their need for the patient, and as the treatment develops the therapist

learns more about the patient but the opposite is mostly not true. While both of these perceptions may be accurate and valid, the reality that the therapist can and likely will experience deep shame when working with disorganised attachment complicates the principle of the therapist's buoyancy. I wonder about another kind of shame that may have arisen within Wingfield Schwartz (2012) after communicating her feelings to Ann. Stein (1997) referred to this as "shame of excess" (p. 114), experienced when a therapist realises they may have spoken too expressively, freely, or passionately, with a patient, or acted with spontaneity or excitement that they fear comes too close to impulsivity or loss of professional conduct (Stein, 1997). I have experienced this within myself from time to time, questioning whether my natural expressiveness and verve helps or hinders the therapeutic process. There is also an unfolding realisation that I have an internal image of what a therapist needs to be like or should be like (more settled, less reactive, more secure). Where it came from or what it means remains shadowy, but what lives is the shame of consciously and unconsciously measuring myself up to it.

With disorganised attachment, there is a particular poignancy to the transference and counter-transference experience of devastating shame because it is often evoked during periods of therapeutic intimacy. The energies of trauma, shame, and persecution at the heart of disorganised attachment can feel sadistic, brutal, and anti-life, because new relational opportunities can be registered as potentially re-traumatising and condemned (Kalsched, 1996). It is perhaps worth considering, as Wingfield Schwartz (2012) does, the attributes of the therapeutic relationship that amplify shame for the client and keeping them in mindful awareness. Shame generates a specific relational complexity in psychotherapy because it is one situation in which the usual ease a patient might experience in sharing and discussing their feelings does not happen (Stein, 1997). Discussing feelings of shame can be uncomfortable, contributing to collusion between therapist and patient (Stein, 1997). Where both parties feel overwhelmed or stuck in their shame, what is painful may be avoided, and where shame is completely absent, perverse or narcissistic enactments could occur (Stein, 1997).

Ann bears violent shame in wanting to be able to 'have' her therapist, while Wingfield Schwartz (2012) also seems to suffer shame, feeling unable to reach Ann. With the letter she writes to Ann, she seems to be saying *I want to have you too, but I also feel I am somehow failing you* (Wingfield Schwartz, 2012). As Fonagy and Target (1995) describe, the spectre who has been shamed, degraded and humiliated is sometimes the therapist and sometimes the patient. There is more of a need to welcome the "undeveloped, empty, unspeakable, and profoundly non-related parts" (Grossmark, 2018, p. 3) that struggle to be verbally expressed by patients with disorganised attachment patterns. However, Wingfield Schwartz's (2012) continued presence in "living through"

(Grossmark, 2018, p. 18) relational experiences with her patient Ann has already provided the nourishment from which Ann can communicate with such sensitivity and reflexivity in her letter. I wonder what it would be to acknowledge that there may be a "scar" (Balint, 1979, p. 179) within each of us which "cannot be 'analysed' out of existence" (p. 179). The scars exist not despite the truth of the love Wingfield Schwartz and Ann share in their therapeutic relationship, but alongside it. That we have to "get on with [ourselves], knowing all the time" (Balint, 1979, p. 179) we have such unamenable scars, may not be a totally bleak reality, but sober and empowering one.

Chapter 4: Discussion

Summary of Findings

In this chapter, I summarise the findings of the research, contemplate implications for psychotherapeutic knowledge and clinical practice, and offer directions for future research. Having the opportunity to discuss the value, ethics and limitations of this study, I will turn towards some my personal learnings and conclusions from this dissertation.

I began the research asking: how does the psychotherapeutic literature help us understand the relational complexity of psychotherapy with adult patient's presenting with disorganised attachment? During the hermeneutic "reading, searching, intuiting, thinking, talking, writing, letting-come process" (Smythe & Spence, 2012, p. 12), I held in mind diverse psychoanalytic, psychodynamic and attachment perspectives relating to my research question. During Chapter 3, I used clinical case material to organise, integrate, and further explore what I had discovered in the literature. I have investigated how early attachment trauma becomes activated in the context of the therapeutic relationship, and the resulting experiences of emotional dysregulation, dissociation, fear, vulnerability, shame and antagonism within the therapeutic dyad. I have sought to make connections between these feeling states and how they may affect relationality during the therapeutic process, including qualities of mutuality and intersubjectivity. The current study is centred in the desire to de-mystify and offer some spirit for the exploration of issues of separateness and relatedness which can feel impenetrable.

The research can be deconstructed into another question: why might the therapist feel the way they do in the therapeutic encounter with disorganised attachment patterns? Reflecting on my findings in Chapter 3, I have identified three star-bright connections which work as guides to facilitate understanding. Firstly, trauma disrupts temporality and the sense of the patient's "being-in-time" (Stolorow, 2015, p. 133). Seemingly innocuous moments in the therapeutic relationship can activate penetrating autonomic and somatic responses which originally served to moderate early pain and overwhelm but are now disconnected and/or morphed from their initial contexts. However, when feelings of abandonment and terror are always on the new horizon, these historical realities cannot be resolved and faced successfully (Wallin, 2007). As discussed during Chapter 3, the way the past manifests itself in the therapeutic relationship, such as bearing models of oneself as confused, incompetent, bad, a victim and/or an aggressor, can be a "ubiquitously disturbing presence" (Wallin, 2007, p. 253) inducing feelings of despair, powerlessness and shame for both parties of the therapeutic dyad.

As Caruth et al., (2019) offered, there is an existential quality to working with trauma, imbued with guilt and mourning, because the therapist's presence is many years too late to prevent

the disaster: "Wake up! Don't you see I'm burning?" Then you wake up and it is already too late; you have missed the burning" (p. 64). Caught in the pressure of intense and early sensations from the patient's lost sense of time, I argue that the therapist is often challenged not to retaliate or withdraw. However, this can demand, or swell to, the radical use or surrender of oneself — a "Levinasian substitution" (Orange, 2015, p. 13) —at least for a time. Therapists make themselves available for the patient's ambivalence, rejection and humiliation. I continue asking how therapists can stay vulnerable enough to remain with the distress of their patients and stay strong enough to survive the therapeutic work with those who will inevitably distrust them (Orange, 2015). Psychotherapists need support to engage in practices which nurture their inner selves (Orange, 2015). It may also be encouraging to recognise resources that therapists possess — clinical training, experience, personal therapy and their personal history (Wallin, 2007).

Secondly, and related to the first star, is the concept that the "what" will be experienced before the "why" during clinical work with disorganised attachment patterns (Stramba-Badiale, 2014). As capabilities for verbal expressiveness, reflective functioning, intersubjectivity and mutuality can be limited within those who have suffered early relational trauma (Grossmark, 2018), there is a tendency for unbearable self-states and emotions to be externalised in the therapeutic relationship through dissociative, aggressive or impulsive states, intense transference/countertransference feelings and/or therapeutic dilemmas (Liotti, 2012). However, experiencing the "what" of what the patient has gone through in their earliest years and is too difficult for them to bear consciously, functions as the crux from which therapists can look inside themselves and make sense of their somatic and emotional reactions to know more about the patient (Wallin, 2007).

I argue for a sort of listening that allows the patient to experience a two-person relationship at moments that "cannot, need not, and perhaps even must not, be expressed in words" (Balint, 1979, p. 174). I posit that it may not matter in psychotherapy "who has the feeling first" (Alvarez, 1993, p. 117). It is known that patients have, and show their therapists, multiple layers or states of mind over time and in different contexts, which means that as they learn more information about the patient, therapists can feel even less sure about who the patient really is (Wallin, 2007). It may be less about 'knowing' the patient through the content of what has happened to them and what they have been through, but moments of being with the richness of a patient's regression and/or relational conflict through which the therapeutic relationship itself traces "a pattern of change" (Stern, 2004, p. 209).

Stramba-Badiale (2014) and Wingfield Schwartz (2012) both describe present moments where allowing, accepting, and anchoring heightened feelings of panic, despair, vulnerability and

shame both within themselves and their patients, opens a therapeutic "window of becoming and opportunity" (Stern, 2004, p. 7).The clinical implication of the "what" being experienced before the "why" is that therapists are tasked with noticing and responding to their subjective experience, as well as non-verbal and bodily communication to help patients access and ultimately integrate what has been emotionally denied or renounced (Wallin, 2007).

The third star is the presence of anti-relational and non-relational parts, and the relational complexity of grappling with a lack of capacity for mutual and intersubjective engagement when working with disorganised attachment patterns. Where there is "unevenness in the maturational environment" (Grossmark, 2018, p. 77), a similar fuzziness can arise in adult functioning. One of the usual intersubjective needs in psychotherapy, the patient's desire to speak to their experience and be known by the other, can be absent, shrouded in shame or hunger, or internally stuck, lost in translation (Stern, 2004). Stramba-Badiale (2014) and his patient Veronica are visited by the manifestation of an unfathomable and terrifying abyss of aloneness, while Wingfield Schwartz (2012) and her patient Ann are staked by the company of a guard of a prison camp, dodging intense, murderous shame. While Veronica presents as softer and perhaps more dissociative in the therapeutic context than the lively passion and anger Ann exhibits, both are affected by the existence of internal parts that isolate them from relational intimacy, and respond at turns with violence, sadism and rage; what was perhaps ineffable and inexpressible at the time of early trauma (Stramba-Badiale, 2014; Wingfield Schwartz, 2012). However, the emergence of these anti-relational and non-relational parts, and their being in *contact* with another person often stirs the presence of debilitating shame. Patients may expect the therapist to react with the same disdain they have for themselves or anticipate that the intimate bond they have in therapy will be lost, disrupted, or broken (Herman, 2012).

Being faced with the non-relational and anti-relational can also be fear-inducing and overwhelming for any therapist. While a therapist may be able to adjust their outward communication of discomfort to patients, it can often be perceived at a non-verbal and implicit level. This can be dysregulating as an impression of the original relationship in which fright of the patient's emotional self may have been uncontained by the caregiver (Herman, 2012). The meaning I make of this, is that meeting the anti-relational and non-relational in patients means evaluating our ability to be a whole person as therapists. For patients to *feel felt,* therapists have to allow these parts of the patient's subjective world to exist in the therapist's mental world (Siegel, 2012), and this may only be possible if therapists are in contact with those parts of themselves. We can ask what it means for therapists to continue to make themselves available for interactions that rouse

attachment sensitivities or a feeling of being done-to, without falling into patterns of emotional distance, dissociation, and avoidance (Benjamin, 2018).

Implications for Psychotherapy

Psychotherapeutic Practice

This research has value for psychotherapeutic practice because it acknowledges the dilemma that disorganised attachment patterns and states of non-relatedness pose for mental health practice. Early relational trauma can leave individuals contending with turbulent inner worlds, and/or controlling selves which obscure the true pain and may not respond to standard psychological treatment (Grossmark, 2018). Hence, the research contributes to discussions about whether the usual parameters of psychotherapeutic practice should be re-evaluated in the context of working with disorganised attachment patterns. I have made an argument for therapists entering the spaces of "darkness, confusion, and non-relatedness" (Grossmark, 2018, p. 78) rather than continually attempting to pull the therapeutic dyad into a state of more organised mutuality.

The current research does not seek to minimise the powerful enigma of relational safety and healing in psychotherapy and stop asking *why*: *why* our patients might feel unsafe, *why* they might not be able to trust others, *why* their relationships look and feel difficult. However, I am advocating that we can get *closer* to the paradox, and that those who have endured early relational trauma can and should be *more* known in their complexity. As Lewin (1994) aptly described, "the most common boundary violations in modern psychiatry consist of excessive distance, not excessive involvement" (p. 294).

Contribution to Psychotherapeutic Theory

I have argued that the soul of the relational complexity in psychotherapy with disorganised attachment is the stride into movement — of mutual action, somatic and sensorial communication (Grossmark, 2018). Clients are "not *not* thinking; they are thinking *in another register*!" (Grossmark, 2018, p. 79). This research adds to psychotherapeutic knowledge by offering perspectives on the experience of relational complexity in psychotherapy and what it might mean for therapists to make use of themselves, so the shattered states of their patients are held to "shine with a kind of sacredness" (Stolorow, 2015, p. 135). I have suggested that providing an "understanding relational home" (Stolorow, 2015, p. 135) for someone traumatised in their earliest attachments *stretches* the therapist, but how to provide this psychotherapeutic care in an ethical and effective way remains a direction for future research.

Future Directions for Psychotherapeutic Research

The current research focuses on the intimate interaction of "two unconscious voices in the room" (Atlas, 2016, p. 10), but future studies could also explore the relational complexity of clinical work with disorganised attachment from an intersectional and/or systemic approach. The realities of racism, sexism, heterosexism and classism, intergenerational trauma and culture, are involved both in the vulnerability to and experience of attachment injuries, and trauma treatment and recovery (Bryant-Davis, 2019). I also cite the work of Nguyen (2007, 2011) to wonder if the experience of disorganised attachment could also be investigated through the lens of "collective psychic injury" (Nguyen, 2007, p. 56) in modern society. There is also great potential to further investigate how therapists might attend to patients somatic and non-verbal communication to access the emotional core of the self during the psychotherapeutic treatment of disorganised attachment (Wallin, 2007).

Strengths, Limitations and Ethics

Strengths

A hermeneutic methodology offered me the grace to attend to my embodied existence and feelings as important information as I was researching. Doing so added a valuable and idiosyncratic dimension, as I could make sense of the literature alongside my lived experience of disorganised attachment. Approaching the research with a hermeneutic consciousness also had strengths in stimulating my capacity to see what is questionable and to "think against oneself" (Schuster, 2013, p. 202) so I could work towards a nuanced and reflective understanding. This is particularly significant because the experience of disorganised attachment is both immersive and imperceptible: it takes the reader right back to infancy and the realm of the implicit, where the tenor of our earliest relationships were "the oxygen in the air" (Balint as cited in Winnicot & Khan, 1965, p. 73). We may never absolutely understand what we have breathed in. The hermeneutic circle of back-and-forth movement, going between fore-meanings and understanding, from the inside to the outside and the outside to the inside, was good practice for my capacity for distance and perspective (Schuster, 2013; Symthe & Spence, 2012).

Limitations

While I used case studies to bring the research closer to the experiential core of clinical work with disorganised attachment, a limitation of the current research is the lack of available literature to delve into the experience of relational complexity directly from the patient's viewpoint. The literature I have drawn from consists of "therapeutic tale"(s) (Atlas, 2016, p. 10). They are creations of the psychotherapist's sentiment and the way they have processed their patient's minds, which

may reveal more about them than the patient. While this is meaningful, there is a critical lack of available information from which to assess therapeutic outcomes more objectively, as psychotherapists do not often get feedback from their clients once treatment is finished (Syed, 2015). I wonder about the ways in which patients narratives of the therapeutic experience may differ from those of their therapists, and at what turns this may be important in developing best practice in psychotherapy.

Ethics

Smythe and Spence (2012) argued that the primary purpose of hermeneutic research is to "provoke thinking" (p. 12). I believe the current research does this through the "dialectical use of question and answer" (Smythe & Spence, 2012, p.12), or movement between knowing and unknowing, reflected in my attention to what feels *difficult* to know, or *cannot* be known about working with the relational complexity of disorganised attachment. The ethical strength of the study is also determined in the commitment to an engaged and transparent approach which both "reveals and conceals the author's "conscious and unconscious interests at play"" (Gadamer, 2007, as cited in Smythe & Spence, 2012, p. 12).

Personal Learnings and Conclusions

The dissertation process has been one of kneeling in and letting myself be on the ground, as my understanding of the relational complexity of psychotherapy with disorganised attachment has shifted and expanded. Early on, I had a conversation with my supervisor which exposed some of my assumptions around what *should* happen in therapy with disorganised attachment. I had an underlying expectation that the patient experiencing internal safety was not only possible, but probable after engaging in long-term psychotherapy. What I have discovered and come to know more intimately is that psychotherapeutic treatment might be less about an aspiration for safety, but more about the therapist making space for as much of the patient's experience as they can. Therapists have the privilege of slowly contradicting and undoing the patient's expectation that there is nowhere for their pain and suffering to come home to. Psychotherapy with disorganised attachment patterns seems to require the therapist and patient to create an environment where regression and complex feelings can be tolerated, much like Bowlby's (2005) suggestion that infants and children can only integrate the parts of their emotional experience able to be accommodated by their caregiver(s).

What makes me a psychotherapist is not that I work with patients, but the commitment I have made to continually *being* with my emotions and developing my capacity for self-awareness

and integration. However, "the work is a coming home that is doubled up within a turning away" (Nguyen, 2011, p. 315). Nguyen (2011) names these mutual and implicit agreements running within us and/or within families, "*d/numbness*" [emphasis added] (p. 315): a psychic dissociation or elusiveness about what we do not want to know, fear to know, and cannot bear to know. I am curious about how accompanying others in trauma gives therapists an opportunity to act and a voice to their grief in ways they might not in their personal lives, and what it means to come out of silence. There are political, ethical, and personal ramifications to exploring the presence of anti-relational, non-relational, non-verbal, diffuse and overwhelming parts of ourselves, and the current research is written with the optimism that the reader will feel *something* enough to start asking their own questions about why they might feel the way that they do when faced with extreme states, whether inside themselves or in relationships with others.

Recently, I was flying alone on a domestic flight where we experienced some turbulence. About four or so rows in front of me sat a mother and her young daughter, a metre divided in space by the airplane aisle. The child would push her small hand and arm out over the distance, tiny nails painted in the same lilac as her mother's sweater, without a sound. Seat-belted and unable to reach over the gap, she would leave her arm and hand there firmly outstretched and patiently waiting. After a few moments, her mother would notice, lean over, take her hand, and then they would begin speaking. Two, three times. I started to cry, my own shame and grief aroused. The experience of disorganised attachment is a cruel one. Letting another person see my need for them, is almost never without a mire of fear, doubt and panic, because the pain of being chronically hurt in my first big love – that between a child and their parents – has left me reeling with exquisite sensitivity. It has been poignant to come to know that the trauma that has happened "cannot be 'analysed' out of existence" (Balint, 1973, p.179), and to realise I no longer want that for myself, anyway. I end this dissertation as a love letter because it has taught me what is most important – coming home to these unmanaged and unmanageable parts of my galaxy, tenderly.

References

Alvarez, A. (1992). *Live company: Psychoanalytic psychotherapy with Autistic, borderline, deprived and abused children.* Routledge.

Alvarez, A. (1993). Making the thought thinkable: On introjection and projection. *Psychoanalytic Inquiry*, *13*(1), 103–122. https://doi-org/10.1080/07351699309533925

Atlas, G. (2016). *The enigma of desire: Sex, longing, and belonging in psychoanalysis.* Routledge.

Arnsten, A. F. T. (1998). The biology of being frazzled. *Science, 280,* 1711–1712.

Balint, M. (1979). *The basic fault: Therapeutic aspects of regression*. Classic Books.

Baradon, T. (Ed.). (2010). *Relational trauma in infancy: Psychoanalytic, attachment and neuropsychological contributions to parent-infant psychotherapy.* Routledge.

Benjamin, J. (1988). *The bonds of love: Psychoanalysis, feminism, and the problem of domination.* Pantheon Books.

Benjamin, J. (2018). *Beyond doer and done to: recognition theory, intersubjectivity and the third*. Routledge.

Blizard, R. A. (2001). Masochistic and sadistic ego states: Dissociative solutions to the dilemma of attachment to an abusive caretaker. *Journal of Trauma and Dissociation*, *2*(4), 37–58. https://doi.org/10.1300/J229v02n04_03

Boell, S. K., & Cecez-Kecmanovic, D. (2010). Literature reviews and the Hermeneutic circle. *Australian Academic & Research Libraries, 41*(2), 129–144. https://doi.org/10.1080/00048623.2010.10721450

Boell, S. K., & Cecez-Kecmanovic, D. (2014). A hermeneutic approach for conducting literature reviews and literature searches. *Communications of the Association for Information Systems*, *34(*12), 257–286. https://doi-org/10.17705/1CAIS.03412

Bowlby, J. (2005). *The making and breaking of affectional bonds*. Routledge.

Bretherton, I. (1998). Commentary on Steele and Steele: Attachment and psychoanalysis: A reunion in progress. *Social Development, 7*(1), 132–136.

Bryant-Davis, T. (2019). The cultural context of trauma recovery: Considering the posttraumatic stress disorder practice guideline and intersectionality. *Psychotherapy, 56*(3), 400–408. https://doi.org/10.1037/pst0000241

Caruth, C. (1996). *Unclaimed experience: Trauma, narrative, and history.* John Hopkins University Press.

Caruth, C., Brochard, R. P., & Tam, B. (2019). "Who Speaks from the Site Of Trauma?": An Interview with Cathy Caruth. *Diacritics*, *47*(2), 48–71. https://doi-org.ezproxy.aut.ac.nz/10.1353/dia.2019.0019

Celenza, A. (2007). Analytic love and power: Responsiveness and responsibility. *Psychoanalytic Inquiry*, *27*(3), 287–301. https://doi.org/10.1080/07351690701389478

Cortina, M., & Liotti, G. (2010). Attachment is about safety and protection, intersubjectivity is about sharing and social understanding: The relationships between attachment and intersubjectivity. *Psychoanalytic Psychology, 27*, 410–441. https://doi.org/10.1037/a0019510

Critchley, S. (2007). *Infinitely demanding: Ethics of commitment, politics of resistance*. Verso.

Crowther, S., Ironside, P., Spence, D., & Smythe, L. (2017). Crafting stories in hermeneutic phenomenological research: A methodological device. *Qualitative Health Research, 27*(6), 826–835. https://doi.org/10.1177/1049732316656161

Degangi, G. A. (2012). *The dysregulated adult: Integrated treatment approaches*. Elsevier Science & Technology.

Dhillion-Stevens, H. (2011). Issues for psychological therapists from black and minority ethnic groups. In C. Lago (Ed). *The handbook of transcultural counselling and psychotherapy* (pp. 105–116). Open University Press.

Field, N. (1991). Projective identification: Mechanism or mystery? *Journal of Analytical Psychology, 36*(1), 93–109. https://doi.org/10.1111/j.1465-5922.1991.00093.x

Fonagy, P., & Target, M. (1995). Understanding the violent patient: The use of the body and the role of the father. *International Journal of Psychoanalysis*, *76*(3), 487–501.

Gabbard, G. O. (2007). "Bound in a nutshell": Thoughts on complexity, reductionism, and "infinite space." *International Journal of Psychoanalysis*, *88*(3), 559–574. https://doi.org/10.1516/E8U0-G516-98G4-11P7

Gadamer, H. (1977). *Philosophical Hermeneutics* (D. E. Linge, Trans.). University of California Press. (Original work published 1976).

Gadamer, H. (2013). *Truth and method*. Bloomsbury Publishing.

Gaztambide, D. (2015). A preferential option for the repressed: Psychoanalysis through the eyes of liberation theology. *Psychoanalytic Dialogues, 25*(6), 700–713. http://dx.doi.org/10.1080/10481885.2015.1097281

George, T. (2020). "Hermeneutics". In E. N. Zalta (Ed.), *The Stanford encyclopaedia of philosophy* (Winter 2021 ed.). The Metaphysics Research Lab. https://plato.stanford.edu/archives/win2021/entries/hermeneutics/

Grant, B. M., & Giddings., L. S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse, 13*(1), 10–28. https://doi.org/10.5172/conu.13.1.10

Grossmark, R. (2018). *The unobtrusive relational analyst: Explorations in psychoanalytic companioning.* Routledge.

Herman, J. (1992). *Trauma and recovery.* Basic Books.

Herman, J. (2012). Shattered shame states and their repair. In J. Yellin & K. White (Eds.), *Shattered states: Disorganised attachment and its repair* (pp. 157–170). Taylor & Francis.

Hoskins, T. (2010). *Māori and Levinas: Kanohi ki te kanohi for an ethical politics*. [Doctoral dissertation, The University of Auckland]. https://researchspace.auckland.ac.nz/bitstream/handle/2292/6089/Whole.pdf?sequence=5

Hussain, Y. (2019). 'I know my roots are Indian but my thinking is Kiwi': hybridisation, identity and 'Indians' in New Zealand. *South Asian Diaspora*, *11*(1), 1–15. https://doi-org/10.1080/19438192.2018.1464697

Jung, C. G. (1985). *Practice of psychotherapy: Essays on the psychology of the transference and other subjects* (2nd ed.). Princeton University Press.

Kanji, A. (2021). *The Therapist's Disorganisation: Ethics of Wounded Healing* [Unpublished manuscript]. AUT.

Kalsched, D. E. (1996). *The inner world of trauma: Archetypal defences of the personal spirit.* Routledge.

Kalsched, D. E. (2020). Opening the closed heart: Affect-focused clinical work with the victims of early trauma. *Journal of Analytical Psychology, 65*(1), 136–152. https://doi.org/10.1111/1468-5922.12562

Klein, M. (1932). The significance of early anxiety-situations in the development of the Ego (A. Strachey, Trans.). In E. Jones (Ed.), *The psycho-analysis of children* (pp. 245–267). The International Psycho-Analytical Library.

Koch, T. (1998). Story telling: Is it really research? *Journal of Advanced Nursing, 28*, 1182–1190. https://doi.org/10.1046/j.1365- 2648.1998.00853.x

Levinas, E. (1969). *Totality and infinity: An essay on exteriority* (A. Lingis, Trans.). Duquesne University Press.

Levinas, E. (1990). *Nine Talmudic readings* (A. Aronowicz, Trans.). Indiana University Press.

Lewin, R.A., & Schulz, C. (1992). *Losing and fusing: Borderline transitional object and self-relations.* Jason Aronson.

Lewin, R. A. (1994). "The concept of boundaries in clinical practice: Theoretical and risk-management dimensions": Comment. *The American Journal of Psychiatry*, *151*(2), 294.

Liotti, G. (2004). Trauma, dissociation, and disorganised attachment: Three strands of a single braid. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 472–486.

Liotti, G. (2011). Attachment disorganization and the controlling strategies: An illustration of the contributions of attachment theory to developmental psychopathology and to psychotherapy integration. *Journal of Psychotherapy Integration*, *21*, 232–252. https://doi.org/10.1037/a0025422

Liotti, G. (2012). Disorganised attachment and the therapeutic relationship with people in shattered states. In J. Yellin & K. White (Eds.), *Shattered states: Disorganised attachment and its repair* (pp. 127–156). Taylor & Francis.

Liotti, G. (2014). Overcoming powerlessness in the clinical exchange with traumatized patients. *Psychoanalytic Inquiry, 34*(4), 322–336. https://doi.org/10.1080/07351690.2014.899783

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development, 50,* 66–104.

Merriam-Webster. (n.d.). *Patient*. In Merriam-Webster.com dictionary. https://www.merriam-webster.com/dictionary/patient

Moodley, R., & Palmer, S. (Eds.). (2006). *Race, culture and psychotherapy: Critical perspectives in multicultural practice.* Routledge.

Nguyen, L. (2011). The ethics of trauma: Re-traumatization in society's approach to the traumatized subject. *International Journal of Group Psychotherapy*, *61*(1), 27–47. https://doi.org/10.1521/ijgp.2011.61.1.26

Nguyen, L. (2012). Psychoanalytic activism: Finding the human, staying human. *Psychoanalytic Psychology, 29*(3), 308–317.https://doi.org/10.1037/a0028778.

Orange, D. M. (1994). Countertransference, empathy and the hermeneutic circle. In R. Stolorow & B. Brandschaft (Eds.)., *The intersubjective perspective.* (pp. 177-185). Jason Aronson.

Orange, D. M. (2011). *The suffering stranger: Hermeneutics for everyday clinical practice.* Routledge.

Orange, D. M. (2015). *Nourishing the inner life of clinicians and humanitarians: The ethical turn in psychoanalysis*. Routledge.

Pernecky, T. (2016). *Epistemology and metaphysics for qualitative research*. SAGE. https://dx.doi.org/10.4135/9781473982956

Poole Heller, D. (2019). *The power of attachment: How to create deep and lasting intimate relationships.* Sounds True.

Rozmarin, E. (2007). An Other in psychoanalysis: Emmanuel Levinas's critique of knowledge and analytic sense. *Contemporary Psychoanalysis, 43*(3), 327–360. https://doi.org/10.1080/00107530.2007.10745913

Schore, A. (2003). *Affect regulation and the repair of the self.* W.W. Norton.

Schore, A. (2010). Relational trauma and the developing right brain: The neurobiology of broken attachment bonds. In T. Baradon (Ed.), *Relational trauma in infancy: psychoanalytic, attachment and neuropsychological contributions to parent-infant psychotherapy* (pp. 19–39). Routledge.

Schuster, M. (2013). Hermeneutics as embodied existence. *International Journal of Qualitative Methods*, *12*(1), 195–206. https://doi.org/10.1177/160940691301200107

Schwartz, R. C. (2013). Moving from acceptance toward transformation with internal family systems therapy (IFS). *Journal of Clinical Psychology*, *69*(8), 805–816. https://doi.org/10.1002/jclp.22016

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). The Guilford Press.

Slavin, M. O. (2005). Afterword. In L. Aron & A. Harris (Eds.), *Relational Psychoanalysis* (vol 2; pp. 111–119). Analytic Press.

Slavin, M. O., & Kriegman, D. (1998). Why the analyst needs to change toward a theory of conflict, negotiation, and mutual influence in the therapeutic process. *Psychoanalytic Dialogues, 8*(2), 247–284. https://doi.org/10.1080/10481889809539246

Smythe, E., & Spence, D. (2012). Re-viewing literature in hermeneutic research. *International Journal of Qualitative Methods*, *11*(1), 12–25. https://doi.org/10.1177/160940691201100102

Steele, H., & Steele, M. (1998). Attachment and psychoanalysis: Time for a reunion. *Social Development, 7*(1), 92–119.

Stein, R. (1997). The shame experiences of the analyst. In A. I. Goldberg (Ed.), *Conversations in self psychology: Process in self psychology* (pp. 109–123). Routledge.

Stein, R. (1998). The poignant, the excessive and the enigmatic in sexuality. *International Journal of Psychoanalysis, 79*(2), 253–268.

Stern, D. N. (2004). *The present moment in psychotherapy and everyday life.* W. W. Norton.

Stolorow, R. D. (2015). A phenomenological-contextual, existential, and ethical perspective on emotional trauma. *Psychoanalytic Review, 102*(1), 123–138.

Stramba-Badiale, P. (2014). Affective attunement, vulnerability, empathy: The analytic experience with Veronica. *Psychoanalytic Inquiry*, *34*(4), 279–287. https://doi.org/10.1080/07351690.2014.899460

Syed, M. (2015). *Black box thinking: Why most people never learn from their mistakes – but some do.* Portfolio.

Symington, N. (1996). *The making of a psychotherapist*. Karnac Books.

Wallin, D. J. (2007). *Attachment in psychotherapy*. Guilford Press.

Wingfield Schwartz, R. (2012). "You can kill me with what you say": Working with shattered states and the breakdown of inner and outer, self and other, from an attachment-based perspective. In J. Yellin & K. White (Eds.), *Shattered states: Disorganised attachment and its repair* (pp. 171–194). Taylor & Francis.

Winnicott, D. W. (1974). Fear of breakdown. *International Review of Psychoanalysis, 1*, 103–107.

Winnicott, D. W., & Khan, M. M. R. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development*. Hogarth.

Yellin, J., & White, K. (Eds.). (2012). *Shattered states: Disorganised attachment and its repair*. Taylor & Francis.

Zimmerman, J. (2015). *Hermeneutics: A very short introduction.* Oxford University Press.