In a Climate of Trauma: Searching for the Power of One's Voice

Now that I have worked with Zoom over a period of four months, there arises a certain pattern of interaction with the members and myself. At first, there was a profound silence. It feels eerie and disconnected. There arises a discussion regarding the latest upheaval and frightening political news. Life seems to be permanently altered. Confusion, loss, and fear along with rage and need, mix in with one another. The silence now seems more comprehensible. People are overwhelmed and traumatized by the change of one's life experience. This remarkable difference in a short period of four months becomes very difficult to process and master. Our joint experience has all the hallmarks of dissociation, for it is all too much to process and understand.

I usually call and end a despairing discussion, and request that someone present a case. With reluctance, someone volunteers.

The following is a case presentation that takes place in group supervision:
The presenter states that this case has been in treatment for over ten years. It feels like it is on an endless plateau, for the patient presents a litany of complaints, dysphoric feelings, and hopelessness. He blames the world for his misery, and the therapeutic dialogue has an aimless similar quality that goes on from one session to the other.

A thumbnail sketch of the patient's history includes the loss of a sibling at age 8 from an incurable disease. The sibling took on the role of the special child, and the result of the child's death led to an enormous depression on the part of the parents. They seemed to give up parenting and withdrew from life. The patient under discussion felt abandoned and lost. He is aware of his history, but insight does not seem to help. The therapist feels for the patient, for he sees the patient as fragile, having been traumatized and overwhelmed by the death of a sibling. Of note, again, is that this sibling was treated as very special. The therapist attempts a number of interventions over the course of treatment. He gently confronts the patient on this endless deluge of sadness and loss. Can he try positive thinking, but this does not work too long. Indeed, whatever intervention he tries, nothing seems to work.

The presenting therapist, with a shy smile, comments that he presented this case some time ago, but could not really follow my recommendations. He simply could not be as tough and firm as I played out the therapist through role playing.

The presenter's father was a very overwhelming and frightening authoritarian individual. The therapist spent many years in treatment attempting to extricate himself

from a very traumatic relationship. Their mutual fragility, patient and therapist, was seen as some rationale as to the therapist's identification with the patient.

I pointed out to the presenter that our connection, his and mine, was a friendly competitive one. He would often take issue with how I would work, and simply would reply when I would offer interventions he replied “that this is simply not right for me.” At the same time, he was often impressed with what I had to say, and admired the way I worked as a therapist and supervisor. We then went back to roleplaying. The patient, as the presenter played out, was complaining about his work supervisor who was ducking his responsibility in dealing with lawyers. As the therapist, I inquired whether the patient was also ducking his responsibility in confronting his supervisor. He too had a responsibility in taking care of himself. The presenter smiled and said that was helpful. We then turn to a more clinical framework, and discuss the subtle differences between aggression and sadism; rage and self assertion; internal and external power.

I commented that throughout the current mental health literature there is much emphasis on attachment and self issues. Shame is often seen as an important organizer of defenses and the internal psychic experience. Guilt, however, is rarely discussed as a central rubric of treatment intervention. When we do experience guilt there is a feeling of dread and a fear that something awful can happen; there can be fears of retaliation and punishment for one's impulses. For some, even the thought stimulates guilt and dread. However, there are many manifestations that serve against the feeling of guilt. Guilt as a sense of dread and fear that something awful will happen; the potential of retaliation and punishment for one's impulses. For some even the thought stimulates guilt. Many people withdraw or avoid situations where they are exposed to competition for fear of attack or aggression. Depression can act as a safe haven and becomes an avoidance of self assertion and affirmation.

We often confuse the difference between external and internal power. There is the authoritarian experience where power becomes expressed through submission and domination. By contrast, an internal experience of power reflects the ability to know who and what you are and be able to stand alone in spite of attack or derision. This ability to possess one's voice and speak with an inner conviction and belief in oneself becomes a very different affect state from being omnipotent or grandiose. The latter violates boundaries. Those with an inner sense of power respect the limits and boundaries of others. This sense of internal power comes through a deep sense of self awareness. Sadism and masochism are invariably connected to one another. When we hurt we often provoke being hurt. They go hand in hand and are glued to one another.

In this society, we are exposed to a great deal of external power that demands submission through fear or intimidation. Occasionally, we discover our heroes who are forthright and authoritative, without demanding submission or worse still, a very binding dialogue of hurt and being hurt. Sadomasochism binds, whereas aggression frees.

This brings us back to the area of guilt. When there is little opportunity to test one's aggression out in a safe setting against one's authority, there arises a fear of one's own power. When either we experience a frightening authority or an absent one, grandiosity which underlies a good deal of guilt takes a firm hold of the personality. Ideally, when there

is warmth and yet an experience of aggression and differentiation between one party and the other, there arises a safe environment where testing out one's power is safe and validating. Structure and boundaries, then, become a landmark of good parenting. Obviously, when boundary setting becomes overly restrictive, or where safety and protection is absent, there is no room to test out the limits of one's boundaries and the development of mutual respect.

I offer this clinical framework to the group, for guilt is not readily experienced in the everyday dialogue of life. The more structure we offer, the more possibility of separation and individuation occur and the less likelihood of either suffering or idealization and to substitute for an authentic identity development. Too much empathy can be suffocating; too little can further alienation and loss. These issues cannot be readily explained to patients. Ideally insight arises out of a therapeutic experience of two people where boundaries are clear, empathy is apparent and authenticity becomes a defining characteristic of a good therapeutic experience. Patients who have achieved a level of object constancy are much more capable to integrate cognitive formulations. today, the majority of patients, however, require a therapeutic experience before they acquire insight and understanding.

As therapists, when we are admired or idealized, we can be on the lookout for being controlled through surface adulation that hides the contempt and devaluation. As therapists, when we become frightened of criticism or attack, we may find some of the underlying issues that lie hidden in the projection. Thus, a patient who quizzes and challenges you on the first interview may have fears of being exposed and humiliated in the therapeutic dialogue.

A member of the group commented that when she was able to express anger towards me she felt relieved and exhilarated. It felt liberating and exhilarating. One member of the group observes similarities between the presenting patient and his own history. He then proceeded to offer an example of how he would work with this particular patient. He expressed much more empathy and holding as a way of working. I wondered to myself whether he too was trying to differentiate himself from the leader. This was not the time or place to go into that example more thoroughly.

We live in an age of busyness and achievement. One has to be comfortable in ultimately knowing what you want and the ability to accomplish our goals. At the same time aggression can be manifested as a form of ruthlessness that covers over a fear of shame or humiliation.

These comments are articulated not to deny the power of very early infantile experiences, but to place guilt, shame and anxiety in a proper perspective. Anxiety can be experienced as a feeling of helplessness; shame describes the shrinkage of self experience, whereas guilt becomes an experience of dread and fear of retaliation.

Much of what I have described has been part of traditional psychoanalytic literature. The recent developments of early infant child research are important. Yet, they do not spell out the entire picture of the struggle to be alive and integrated. These effects are intrinsically

related to power and self affirmation when we are also living in a time of trauma, powerlessness and a loss of one's voice.

The patient that was presented certainly had trauma in his background. Thus, the added complication, may be in the fragility of this patient along with the important developmental conflicts that are unresolved. In this essay I also make a difference between defenses and reactive hostility. When we thus see the complicated mix of the transference and countertransference relationship, the impact of trauma and the developmental conflicts, we can readily see how the working through of these complex issues may demand both the uniqueness of being authentic as well as being grounded in a clear clinical framework.