

Hidden Trauma Within the Care-giver Relationship

An Account of Clinical Work with a Client Labelled as Having a “Borderline Personality Disorder”

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This is a story about hidden trauma, unbearable vulnerability, and how an attachment-based psychotherapy impacted on a patient given the diagnosis of having a borderline personality disorder. Bowlby’s attachment theory together with the neuroscience of Allan Schore was paramount in understanding her internal world, her relational history, and the affects she displayed when first presenting herself. She had been in the National Health Service (NHS) system one way or another for fourteen years.

The *Diagnostic and Statistical Manual of Mental Health Disorders* currently the *DSM-IV*, published by the American Psychiatric Association lists ten personality disorders. Borderline personality disorder is characterised by “extreme black and white thinking, instability in relationships, self-image, identity and behavior often leading to self-harm and impulsivity”. Causations are listed as:

genetic dispositions as well as particular life experiences which may or may not include particular incidents of trauma or abuse. Child abuse and neglect consistently evidenced themselves as antecedent risks to the development of personality disorders. (American Psychiatric Association, 1994: *DSM-IV*, section 301:83)

I did not find this description useful because it shut down other ways of thinking about the client and the role of hidden trauma. This diagnosis pathologised her and gave her a belief that her “borderline personality disorder” was a life long condition.

During my reflections on our work together, I came to understand that there was a different causation for the client's difficulties, a more elusive reason because in a sense it had been "hidden" and "concealed" within her early attachment history.

This was not about a life that had known obvious trauma but it was about a life that had been lived in quiet desperation. There had not been a history of child abuse, cruelty, loss, death, or deliberate neglect. There were none of the usual traumas that we consider when thinking about what leads to mental health difficulties in adulthood. What I uncovered was an intergenerational, early disorganised attachment with a "benign" but dissociative care-giver who had prioritised the demands of the external world over her infant's developmental and emotional needs.

Karlen Lyons-Ruth (2006) writes:

Primary experiences of threat in infancy include the threat of separation from the caregiver and the threat of having little caregiving responses to the infant's signals of distress. The relevant traumas of infancy most often result from hidden traumas of caregiving unavailability and interactive dysregulation . . . These hidden traumas are woven into the fabric of interaction between caregiver and infant and do not necessarily stand out as salient events to the observer. (Lyons-Ruth, 2006, p. 71)

Kay (not her real name) was eighteen years old when her parents decided to move to Wales. The sale of the house and the subsequent separation from her family was a catastrophe for Kay although her mother had assumed that their daughter would be coming with them. This event was a major re-enactment of an early, disorganised attachment relationship and triggered the collapse of the self.

She felt abandoned but nothing could be expressed because she had always been told that she "shouldn't upset anyone" (i.e., not be angry), a parental rule that she had never questioned. She felt she had no right to spoil her parent's retirement "dream" but at the same time she felt overwhelmed by her feelings of anger, fear, and insecurity: feelings that could not be expressed or listened to. Her choice was to remain living in the same area with friends.

Her behaviour deteriorated over the following months and was to be the start of a steady decline. She attended a day hospital as a psychiatric outpatient. When she was twenty-one, she went to live in an NHS therapeutic community where she stayed for five weeks but then at twenty-three she was admitted to a psychiatric ward where she stayed for two years. She was discharged to live in a hostel for people recovering from mental health problems but was asked to leave here for self-harming again and was taken to another psychiatric ward. She was discharged from there after a month and allowed back to the hostel.

During her period of time in hospital she had been offered various treatments. Drugs, of course, some sessions of family therapy, and twice-weekly

individual psychotherapy. One of the conditions for receiving psychotherapy was that she had to undertake that she would not self-harm. If she did, the therapy would be withdrawn. This is precisely what happened and Kay was abandoned by the service. They said that she had broken a boundary and that after eighteen months there had been no improvement. Further therapy they felt was “unlikely to be beneficial”. Although she requested that her psychotherapy be continued, it was refused. They said that she could see a therapist privately but that they would not give her any names, as they “did not support that option”. Letters written by the consultant psychotherapist seem to imply an unspecified sense of blame towards this patient for failing to respond to treatment, but then any therapy that carries an implicit threat to the patient is doomed to failure.

The rejection was painful for Kay. She felt abandoned and this was another re-enactment of the early, disorganised attachment relationship. It damaged her further by increasing her sense of humiliation, failure, and hopelessness.

She was given accommodation in a housing community for people who had mental health problems but were allegedly “in recovery”. There was a support system of key workers who provided both practical and friendly advice. She was under the care of a psychiatrist whom she liked and whom she saw for approximately ten minutes every six months and who maintained her medication. Latterly she had been attending a therapeutic group run by the NHS on a weekly basis, until it was brought to a close because of funding difficulties, and she had also completed some courses in gardening run for people with learning difficulties. She had a very limited social network. As she told me about her daily life, the word that came to mind was “impoverished” and the feeling I had was a sense of utter hopelessness.

Kay could not articulate what she wanted from her therapy. She said she felt depressed, was self-harming and wanted to feel better but she was unable to elaborate. She was taking 375 mgs of Venaflexine and was given Diazepam for emergencies. Her medication was washed down with alcohol and she was smoking heavily. We arranged twice-weekly sessions. I did not know it but it was to be the start of seven years of work together.

She was thirty-three years of age but looked considerably younger. She was pale, delicate, thin, quite waiflike and her hair was shaved so short, her scalp could be seen. She wore jeans, boots, and a jacket that seemed too big, which I later learned was about concealment and protection, and she carried a large, heavy duffel bag that looked as if she carried the world on her shoulders. There were long pauses when she spoke in a voice devoid of affects and she had difficulty finding words. She jiggled her leg continuously. I could not tell if she was dissociated or if the drugs she was taking were making her appear to be. Perhaps it was both. She rarely met my gaze and rarely offered comments or information without being asked. Kay’s narrative, such as it was, was confusing and she often forgot in what order events had happened to her. In fact, her

memory seemed to be somewhat compromised. She had little sense of self, or of her own subjectivity or agency.

She was always on time for therapy, compliant, and constantly checking fees, times (which never changed), and holidays. The therapeutic relationship filled her with anxiety and she became preoccupied with the possibility of losing it. She always took her holidays when I took mine and only arranged to visit her parents when it did not interfere with therapy. She was often tearful when her therapy sessions ended, she wanted to stay and found it painful to leave. This felt like a re-enactment of what had been missing in the mother-child relationship within the transference.

The outstanding feature of her thoughts and comments at this time was her extreme self-loathing, self-criticism, and irritability with herself, the rigidity of her own beliefs and a preoccupation with rules and responsibilities about what she should and should not do or be. Depression, shame, and self-blame seem to lay over her like a dark shroud.

What was it that had made this young adult who had no apparent or specific trauma in her life come to have the affects and behaviour associated with post traumatic stress disorder (PTSD) and so-called obsessive compulsive personality (OCP)?

Her post traumatic stress disorder symptoms took the form of self-harm, panic attacks, ceaseless hyper anxiety, and depression. Her OCP symptoms were an obsession with cleanliness, constant checking and rechecking facts, and her own rigid, weekly timetable that had to be adhered to at all costs.

During the first eighteen months of therapy with Kay our time was taken up with a grieving process. Kay had been in a five year relationship, which she knew was coming to a close. The ending of this intense, extremely volatile relationship where both individuals appeared to have been co-dependent was distressing for Kay although, interestingly, she had not named it as being one of the reasons for coming into therapy. Her thoughts obsessively focused on trying to understand her partner's unwillingness to remain friends and the potential separation was causing panic. I learned that Kay's partner had been her former counsellor, was married, and that Kay was giving her a considerable amount of money each week out of her own meagre financial support system.

I suggested to Kay that the some of the money she gave to her partner should now be spent on her therapy. She agreed but this was the catalyst that her partner used to sever all contact and Kay now had to look at other dynamics within the relationship. These included her adapted behaviour towards her partner, her tolerance of exploitation, her fear of separation, and her extreme reactions of intense anxiety that had been a feature throughout the relationship. As we looked through the prism of this relationship we slowly began to make connections with her history and the dominant attachment relationship, which was with her mother.

I learnt that Kay was the youngest of three children. Her mother already had a four-year-old son, a two-year-old daughter, and now another baby to care for. She had three children under four, had no help, and could not depend on an extended family for assistance in daily life. Her father seems to have been a benign, absent father always at work or doing DIY in his workshop at home. A week after Kay was born, the family moved house, and there was another move some time later when Kay was just under a year old. The new house itself needed a lot of repairs, which Kay's parents undertook to do themselves. In the same period, Kay's mother went into hospital to have a sterilisation. She also took driving lessons. This was a busy woman.

One of Kay's earliest memories is of clinging to the hem of her mother's dress. I learnt, too, that she went on sitting on her mother's lap until well into her teens, unusual behaviour for an adolescent.

Kay's mother seems to have been stressed, chaotic, and never able to catch up with herself, which continues to this day. In fact, we now have come to an understanding that she is dysregulated herself. Another early memory that Kay has is of seeing how stressed her mother was and intuiting that the only way to be safe was to be as near to her as possible.

Proximity was a substitute for attunement because this distracted and dysregulated mother was not truly present for her youngest infant. If she had been more emotionally available, the need for clinging and proximity would not have been so paramount. Though physically close, Kay did not have a sense of felt security resulting in the complexities of a disorganised, and ambivalent-preoccupied attachment.

In the first early months, affect regulation is the fundamental tool of communication between a mother and her infant but it is more complicated than that. We now know that all babies are born with a predisposition towards attachment.

As Allan Schore puts it:

Through visual-facial, auditory-prosodic and tactile-gestural communication, a caregiver and infant learn the rhythmic structure of the other and modify their behavior to fit that structure, thereby co-creating a specifically fitted interaction. Via this contingent responsiveness, the mother appraises the non-verbal expressions of her infant's internal arousal and affective states, regulates them, and communicates them back to the infant. (Schore, 2012, p. 75)

If a care-giver, for whatever reason, is unable to provide reliable and safe affect regulation, the infant cannot internalise the care-giver's soothing communications. If not enough attention and time is given to affect regulation; if it is rushed, delayed, or becomes unpredictable by an emotionally absent, preoccupied, dissociative care-giver, the secure base that Bowlby speaks of cannot be established and the emotional bonds between care-giver and baby will be insecure.

There is a family story that is relevant to this period of time. Kay's mum and dad had gone out and had forgotten that they had left Kay completely alone in the house. This would have been when she was less than a year old. According to her parents, when they returned, Kay was sleeping soundly in her cot. The story is often repeated in the family, everyone laughs except Kay who continues to feel humiliated about being forgotten. This is a story about dissociation, about forgetting, about the unconscious, and I feel it tells us something about this mother whose own dissociation and ambivalence about this third child led her to forget her infant.

Children with an ambivalent attachment pattern are those whose first relationship proves to be confusing, unreliable, and contradictory, the source of their secure base is the same source that also feels unsafe. When awake, they oscillate between states of expectation and withdrawal and feeling safe in neither because of the unreliability of the relational environment. The unreliability comes from sometimes experiencing an attuned response but at other times not, so the responsiveness of the care-giver is inconsistent.

Parents of these children, often have unresolved past emotional difficulties and/or traumas resulting in an inability to sensitively attune to their children's emotional needs in a consistent, predictable way and attachment issues become intergenerational.

They may also have issues around seeing their children as being separate from themselves. One of Kay's complaints about her mother was that she would always say to her "you are just like me", a phrase that rang out like a bell down through her childhood and that filled her with anger.

We now know that all attachment systems, self-regulations, and internal working models emerge from affect regulation within the mother/care-giver-baby dyad and that these processes begin at birth. Pre-conscious and preverbal, the visceral and emotional affects of the dyad are registered within the right hemisphere of the infant's brain.

Allan Schore writes:

The dyadic implicit processing of non-verbalising attachment communications are the product of operations of the infant's right hemisphere with the mother's right hemisphere. Attachment experiences are thus imprinted in an internal working model that encodes strategies of affect regulation acting at implicit non-conscious levels. (Schore, 2012, p. 34)

Failure of this vital process of affect regulation between infant and care-giver has catastrophic consequences for the infant resulting in hidden trauma. The infant cannot begin to internalise or emulate the process of self-regulation from the care-giver and cannot reach homeostasis or the beginnings of self-cohesion.

Bateman and Fonagy write:



The development of the core self occurs in the affect regulatory context of the early relationship. Unsurprisingly the disorganisation of the attachment systems results in the disorganisation of self-structure (Bateman & Fonagy, 2006, p. 11).

Affect regulation is so fundamental that without it a child will not be able to develop any resilience to meet external challenges. A failure of self-regulation has huge implications for the (normally) first separation that children face with schooling. Kay had difficulties from the start that continued throughout her childhood and into adolescence. Her stress response to separation together with her constant dysregulation severely limited her social and learning potential. Her defence against these overwhelming feelings of high arousal was to dissociate from the cause of the distress, and she became known to the teachers as quiet and withdrawn; a child who seemed to be slower at learning than her classmates. Kay felt the humiliation of struggling to keep up and this is when her shame became conscious. She perceived herself as being stupid, and as someone who could not remember anything, an attitude that became deeply imbedded in her opinion of herself. As a result of what she perceived as being her own fault she had meagre self-confidence and no self-esteem.

It took me time to understand the impact of this distracted mother's lack of emotional presence with affect regulation in the first years of her daughter's life because Kay's medication, her use of alcohol, her own dissociation and depression concealed her chronic self-dysregulation. It was only after Kay's depression began to lift, after we had reduced the medication and alcohol, that I gradually became aware that she had a complete inability to regulate herself on any level so that she was always in a constant state of hyperarousal that the medication barely seemed to address.

Kay had developed all kinds of strategies to manage the hyperarousal: concrete, rigid thinking, an excessive preoccupation with her needs, and OCP behaviours. For instance, she would carry the heavy duffle bag around with her, even in the hottest weather because she said she never knew if she was going to be too hot or too cold, hungry or thirsty, comfortable with what she was wearing or not, and so took everything with her to try to control her feelings of uncertainty. These feelings were the uncertainties of self, which she also projected on to her body. Her ability to think (left brain processes) had been seriously impaired by her overactive stress response. Ordinary activities like shopping were traumatic because she was fearful of making a wrong choice. She could not trust herself to make a decision. To find herself in any new situation was torture and her social anxiety was chronic. She had no way of regulating her extreme anxiety and many hours were spent suffering: anticipating disasters, over reacting, hyperventilating, or obsessing about parts of her body.



There was a complete failure to build self-confidence or self-esteem based on any good experience, her internal working models wiped them out. The only way she seemed able to get rid of overwhelming negative feelings about herself was by self-harm, projection, and projective identification, which led to more confusion, as she was unable to differentiate between the feelings that belonged to her and those that belonged to the other so enmeshment became another issue.


Her failure to manage her stress response was so severe that I found that I was constantly soothing and normalising every small disruption and it was not enough. As soon as we had soothed one situation, another would arise, and then another, and another. I began to understand that this need for soothing was an attempt to find what had been missing unconsciously in a re-enactment of the mother–baby dyad in the transference with me. Back then—when she was an infant, there were no words, language, or thoughts but a tiny body—I feel that there must have been times when this infant had fallen into an abyss of disconnection because of her mother’s emotional absence resulting in unbearable vulnerability and terror, which became the foundation of Kay’s chronic dysregulation. Over the years, Kay’s dysregulation had become so entrenched that her cognition had become disorganised, disorientated, and confused and her emotional self operated from a guarded, distrustful place of never feeling internally safe or indeed certain of her body.

According to Allan Schore the baby’s brain development depends on his or her relational experiences that are in turn derived from the early attachment relationship (Schore, 1994). In the first year of life, the orbitofrontal cortex is most active. It is the domain of emotional management and self-regulatory systems and is the controller of all the right brain activities. The dominant form of communication between care-giver and infant at this first stage is done by mutual looking, gazing, and seeing. This initiates the right brain activities that begin the process of socialising the infant to live in their particular environment, and manage emotional and visceral impulses that will eventually lead to learning self-regulation.


After the first year the right and left sides of the orbitofrontal cortex begin to knit together linking the expression and management of feelings. (Gerhardt, 2004, p. 50)

This neurobiological process predicates the verbal self in the second year of life. The dorsolateral cortex and the anterior cingulate situated in the left part of the brain become activated. This site is known as the “working memory”; the place where we can begin to hold on to and think about our feelings. Language and some rudimentary sense of self can now be expressed. “I want this, I don’t want that.” Feelings are crystallised into words by an attuned care-giver. Language, as well as looking, now increases the emotional range and the

infant begins a more complex process of learning to differentiate between increasingly complicated feelings using both looking and language to understand meaning.

 A third neurobiological stage emerges out of the verbal self at about three years old because memory can now be stored in the hippocampus and used to create a narrative self. "I am going to the park today." These incredible processes beginning at birth are normally in place by the age of three and are dependent and organised within the early attachment relationship. However, when a baby becomes so distressed through a repeated failure of care-giving, the stress response becomes over activated and the normal developmental processes of the brain become compromised.

One key part of the subcortical response to stress is the hypothalamus situated in the centre of the brain. It plays a key role in dealing with any stressful experiences that overload the system and upsets these regulatory routines. In particular, the hypothalamus can be activated by neurochemical messages from the amygdala which reacts to social situations that generate uncertainty or fear by firing off chemical messages in various directions. The stress response system, the HPA axis (the hypothalamus triggers the pituitary which in turn triggers the adrenal glands) is activated and the end result is that the adrenal glands generate extra cortisol to produce extra energy to focus on the stress and to put other bodily systems on hold whilst it is being dealt with. (Gerhardt, 2004, p. 59)

 When cortisol floods the body, receptors are needed to disperse it when it is no longer needed. These are also found in the hypothalamus and become reduced if constantly used. Damage to the receptors leads to a failure of dispersal of the cortisol, leaving the individual in a constant state of arousal and anxiety. Neglect activates the stress response in a baby which, because of the brain's early plasticity, then becomes biologically embedded and part of the system and subsequent behaviour (Hertzman, 2000).

I believe that Kay's mother's emotional absence during the first three years of her daughter's life caused cumulative, developmental trauma at a critical time during the brain's development. Kay's chronic dysregulation was the symptom of hidden trauma.

This failure was never deliberate but a combination of the mother's own attachment history, her own dissociation, ambivalence about this third child, her own dysregulation, life events, and an ignorance of what mattered. It is interesting to note that all three children have had seriously disrupted relationships with this mother although Kay's siblings have had more resilience to deal with them.

Puberty became another challenging time because Kay was forced to confront the changes in her body and the beginnings of her body dysmorphia and self-identity now emerged. She loathed her breasts, she was concerned with

bodily hair, which became a matter of shame, and she hated other parts of her body which included her face. She had always hated wearing clothes for girls but now it became an issue. She found it difficult to be seen, to be looked at, or see herself in a mirror. This was not just about pubescent adjustment to bodily changes, but a reflection of her unresolved, disorganisation of her self-structure, her unconscious, and unexpressed anger towards her mother and I wonder too if it was about traces of early memories of not being “seen” as an infant and child both emotionally and bodily. Once again the early disorganised attachment turned a normal developmental stage into a self-regulatory crisis.

When Kay was in her twenties she went through all the medical procedures, including visits to a psychiatrist, to have her breasts removed but pulled out at the last moment. This desire to rid herself of her breasts could be interpreted as a desire to rid herself of the anger she felt towards her mother that had been turned inwards and that would have resulted in self-mutilation had Kay finally gone through with it.

During the first months of therapy, I became aware of how much Kay was drinking and I was concerned as her medication expressly advised no alcohol. Regulating her feelings with alcohol had begun when she left home to attend an agricultural college when she was seventeen. She had found this separation so traumatic that the only way that she could stabilise herself was with alcohol. She had begun to drink as a way of self-medicating, regulating, and soothing herself. When she was drunk she ceased to feel.

Most nights would find her in the bar at college and later on when she was mixing with other patients in the NHS, she regularly saw them drinking alcohol and taking illicit drugs while taking their own prescribed medication. Their example had made her dismiss the dangers. As she gradually began to understand why she was self-medicating with alcohol, the need to do so lessened until she stopped altogether. She now allows herself to drink occasionally but it is not out of desperation because she cannot manage herself any other way.

Kay was also self-harming and this was, along with the grieving process, an urgent issue that we needed to address. Mostly her self-harm was limited to cuts with a razor on both arms and her thighs, although in extremis she was known to cut her face. It was essential that she had someone to turn to when she felt the need to self-harm. I suggested that she telephoned me and wanted her to know that talking about what was troubling her was better than harming herself. I also wanted her to know that she was not alone anymore. She agreed to do this and only ever phoned me two or three times after which she was more able to control her cutting.

Self-harm occurs when the individual feels powerless to switch off intrusive, persecutory, and painful thoughts which threaten to engulf them. It is as if they

have a tape playing in their head, that they cannot distract themselves from, or stop the overwhelming feelings of self-hatred, hurt, and anger. The ritual of finding the self-harm instrument, a piece of glass, a razor, or a blade, and seeing the flow of red blood brings a sense of relief and some semblance of control and coherency.

This self-harm activity could be linked to alexithymia which is a term used to describe the inability to recognise feelings and put them into words. There were no words for feelings because this family like so many, did not know and still do not know how to talk about feelings. The rudiments of this fundamental task evolve out of the early attachment relationship between the care-giver and the baby.

As Sue Gerhardt writes:

The difficulty of putting feelings into words probably originates in the early parent-baby communication. If a mother figure does not teach her baby to put bodily feelings into words then he may not develop the capacity to organise his feelings and contain tension through his own mental processes without constantly relying on others. (Gerhardt, 2004, p. 59)

Kay's alexithymia can also be directly linked to her body dysmorphia where feelings, perceived as shameful, could not be put into words, thought about, or understood. This is another right brain hemispheric dysfunction and a specific right to left deficit of the callosal transfer. Basically there is a failure to be able to think about feelings because the connection between the left and right brain has become weakened through dysregulation. Without the thinking capacity of the left brain, which helps to contextualise and ameliorate feelings, they remain persistent and unprocessed and if they are negative, remain a threat that undermines resilience and self-esteem.

After about three years of work I wondered to Kay if she needed to be taking as much as 375 mgs of Venaflexine. She hated the side affects of the nightly sweats and I found it difficult to work with someone who was so very removed. Over a three year period and with her psychiatrist's agreement we slowly began to lower the dose. It was a challenge for both Kay and myself, as Kay now had authentic feelings to deal with.

As Adam Phillips writes:

There is something intrinsically and unavoidably humiliating about being a child. No one recovers from the sadomasochism of their childhood. We may not want to think of the relations between parents and children as power relations: indeed it may sound like a perversion to do so. . . . but to put it as cutely as possible, feeling big always depends on someone feeling small. (Phillips, 2013, p. 19)

He goes on to say that there is a sadomasochistic element about the relationship between a child and parent because of the child's dependency and attachment

needs and how the parents choose to manage their child's frustration. Frustration can either be managed with humiliation, fear, and punishment (sadistically), or with patience and love.

This seemed worth thinking about because in many ways Kay's relationship with herself and the external world was essentially masochistic and needed to be moved into the place of owned subjectivity and equanimity: a process that had not happened developmentally but had remained stuck in the helpless dependency, and powerlessness of the small child. Kay's parents had tried to support her over the years but I think they had resigned themselves to Kay's state of dysregulation. I wondered if there had been an unconscious, sado-masochistic agreement between Kay and her parents that basically her stress response was her own creation and responsibility and that they had told themselves it was something she had been "born with" thus absolving themselves of guilt.

Understandably Kay hated it and masochistically blamed herself for it: the humiliation it generated, the shame it provoked, the neediness and fear it created, the demands it made on herself, and the constant physical exhaustion that living in such a state of tension caused. We talked about this cycle of dysregulation, and self-attack which helped her to reflect on how her persecutory feelings towards herself constantly perpetuated the cycle. Underneath all her negative feelings about herself was the major issue, her unconscious and unbearable vulnerability that belonged to the traumatised infant who had been abandoned by an emotionally absent mother. Kay had been carrying around this experience and repeated threat since birth. I wanted her to understand that her unbearable vulnerability need not be a matter for humiliation and fear but could become a matter for awareness, compassion, and toleration.

Helping her identify her feeling of vulnerability, stay with it, and talk about it has been a difficult and painful process for her to take in. She clung to her old rigid patterns of thought, she did not want them to be challenged and I had to be careful not to re-traumatise her. Her inner world was so full of bad objects it was difficult for her to hold things in mind and she had a tendency to avoid, withdraw, forget, or be upset.

Brilliantly, she solved a part of the problem by introducing a tape recorder and for the last two years, the sessions have been recorded so she can replay them at home which helps her to think, reflect, and hold on to what we discuss. Her internal processes had also severely damaged her self-esteem, her ego strength, her pleasure, her desires, and her joy. Consistent support and encouragement was needed to uncover those feelings too and to move her into self-acceptance and a sense of entitlement that she too could have good feelings. She had to give herself permission to feel good and hold on to the feeling with awareness. I was also keen for her to join a wider social community outside of the care system.

The fear of recovery was understandably another threat because having a borderline personality disorder diagnosis offered a measure of limited protection while paradoxically providing severe limitations at the same time. To be better was alarming. Kay did not believe she could cope outside of the care system that had become an unconscious replacement of the parental role. The wish to be taken care of had become neurobiologically embedded in her psyche and it was a struggle to give it up.

The dysregulated infant/child needed to integrate and believe in the adult who was metaphorically waiting in the wings, and trust that she could look after her. There was grieving to be done over this lost, early attachment relationship, grieving to be done over this wasted time, and grieving to be done about a system that had traumatised her, pathologised her, and then said they could do no more.

Not long ago her psychiatrist said that there was no need for Kay to be under his supervision anymore as she was so much better. This was rather frightening and although her ability to self-regulate is much improved she continues to need further support to become better integrated and our work goes on.

It may seem that seven years is a long time to be in twice-weekly therapy but Kay has experienced thirty-three years of unrecognised hidden trauma and if you consider what we are trying to do, which is to completely change her internal processes, it does not feel a long time.

Kay no longer takes 375 mgs of Venaflexine, although she continues to take 20 mgs of Citalipram. She does not self-harm or self-medicate with alcohol. She knows that feelings and especially anger may be thought about and expressed without harm to self or others. She is tentatively allowing good feelings about herself to be felt, learning to build self-esteem, and have compassion for herself. She is coming to terms with her body and own her sexuality, and best of all she is beginning to understand that her dysregulation was not her fault and may be repaired with time.

We need to understand that not all trauma is overt just as we need to understand that it is trauma and the trauma of failed attachment systems that is the underlying cause of many of the so called "personality disorders" which so often become intergenerational tragedies.

About three years ago Kay asked me how her desire to self-harm had disappeared. I said because you have been able to share and understand your feelings, there does not seem to be a need to cut yourself anymore. They disappeared unconsciously without you really being aware of it. That is how therapy works. Actually I now think therapy works in Allan Schore's paradigm of the care-giver-baby dyad, right brain to right brain . . . at the wordless, implicit non-conscious exchange in that first period of the developmental brain: the unremembered, the unforgettable domain where being seen and

held by the good enough care-giver is a place of deep safety, sanctuary, and exploration and where the subject is always held in mind and never forgotten. This paper is respectfully dedicated to Kay with love.

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