HEALING THROUGH MIRRORING THE OTHER: A SINGLE CASE ON SHARING VULNERABILITY IN THE THERAPEUTIC RELATIONSHIP

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Abstract

Research in psychotherapy has tried to identify which elements favor and hinder the therapeutic alliance. However, few studies have analyzed how these processes come into play when patients and therapists share the same psychological vulnerability factors. The innovation of this contribution is twofold: 1. For the first time, patient and therapist expose, in a single work, their point of view in moments of impasse regarding their respective roles in the relationship and the emotions and tendencies to action activated by each other; 2. The Cognitive Model of Pathological Affective Dependencies (Pugliese et al., 2023), which focuses on the frustration of basic needs as an antecedent for traumatic relationships, is first applied to therapeutic alliance breakdowns. In relational trauma, there are feelings of distrust, a perception of the world as dangerous and unpredictable, and, concerning others, a belief in unlovability prevails. While the therapeutic relationship provides the basis for processing traumatic experiences through a new relational experience, it is the patient's compromised capacity for trust that makes it difficult to achieve stability. The feeling of powerlessness and helplessness underlying the trauma leads the relationship to oscillate between needs for closeness and distance, triggering an emotional spiral that leads to the interruption of emotional expressiveness, communication, and intimacy. Through a single case, we illustrate the complexity that the therapeutic relationship assumes when it is embedded in a disabling interpersonal cycle in which the patient feels drawn to destroy the therapist's image, even though she feels the need for the relationship and the pain resulting from its loss. The need for security and attachment, coupled with the terrifying fear of losing the other, activates attempts at a solution based on control and the use of power that will constitute the leading cause of the break of the bond and the primary factor in maintaining a long impasse in the therapeutic process, leading to a collapse of metacognition and confusion of roles. The therapeutic setting takes the form of a courtroom in which the patient and therapist remain for a long time trying, through their clinical expertise, to find answers to a single question: Who is the abuser, and who is the victim? This contribution allows careful analysis of interpersonal cycles in relational trauma through an integrated clinical reading of the patient and therapist, supporting the progress of research in psychotherapy aimed at developing increasingly precise strategies to ensure effectiveness.

Keywords: *Adverse childhood experiences, relational trauma, therapeutic relationship, vulnerability factors.*

1. Introduction

The therapeutic alliance constitutes one of the elements underpinning the therapeutic process and is fundamental to its successful outcome. Numerous types of research highlight the relevance of relational factors in the understanding of therapeutic efficacy (Wampold & Imel, 2015; Norcross & Lambert, 2019; Castonguay et al., 2019) and emphasize how the experience of the therapeutic relationship represents a strongly curative element in itself, regardless of the patient's diagnosis. Complex post-traumatic disorder is associated with a pervasive distrust of others (Cloitre et al., 2009), as trusting implies that the patient is at risk of being abused, rejected, or abandoned again (Gobin & Freyd, 2009). Individuals learn to ignore their emotions, shifting their attention to the other, adjusting behaviors according to hypothetical responses from those who are supposed to look after them (van der Kolk et al., 2005). A solid therapeutic alliance is crucial for therapeutic success with adult trauma survivors (Cloitre et al., 2004), as instilling a sense of safety through the therapist's presence can lead to the reduction of dysfunctional coping strategies, promoting

growth and change. Paradoxically, attempts by the therapist to establish a safe and trusting relationship may trigger in the patient the same defenses associated with previous experiences of abuse that require a degree of intimacy, one of which is dissociation (Pearlman & Courtois, 2005). The present work aims to highlight the connotation that the therapeutic relationship can take on in the context of complex post-traumatic stress disorder when embedded in the oscillation between the patient's need for a healthy dependence on the therapist and, at the same time, terror and denial of the same. From a theoretical point of view, the authors interpreted the patient's mental functioning according to the Cognitive Model of Pathological Affective Dependence (Pugliese et al., 2023), which focuses on how early adverse experiences can lead to the development of different pathological parts from unmet needs for love, dignity, and security. According to the model, there are four types of parts that relational trauma can generate, characterized by specific goals, antigoals, and dysfunctional beliefs about self and others: the savior, the unworthy, the vulnerable, and the mixed. In the present case, these parts protect each other with the ultimate aim of not entering the relationship for fear of showing the vulnerable part that would make the patient, in the representation of her suffering, dependent on the other (in this case, the therapist) with the consequent risk of reliving the real and threatened emotional abandonment that reigned in the relationship with the caregiver.

2. Case presentation

The patient is a young woman of 33 and works as a psychologist in a psychiatric community. She asked to start psychotherapy because, about a year earlier, her grandmother, to whom she was very close, died suddenly of a heart attack. This event triggered the activation of the patient's three main anti-goals. She felt unlovable at the idea of not having been able to prevent the event, unworthy of the idea of expressing her suffering, and in danger of the sudden loss. The patient has a brother who has been completely blind since birth. This situation caused deep distress to her parents, whose attention was mainly devoted to her brother, neglecting the patient's basic emotional needs. The parents often delegated to her the role of managing her brother while at the same time asking her to give up rights that her brother could not access. As a result, the patient developed a belief in unlovability, whereby the expression of her emotional needs, in her mind, has no right to exist apart from the suffering of the other.

Figure 1. Young Schema Questionnaire (YSQ-S3).

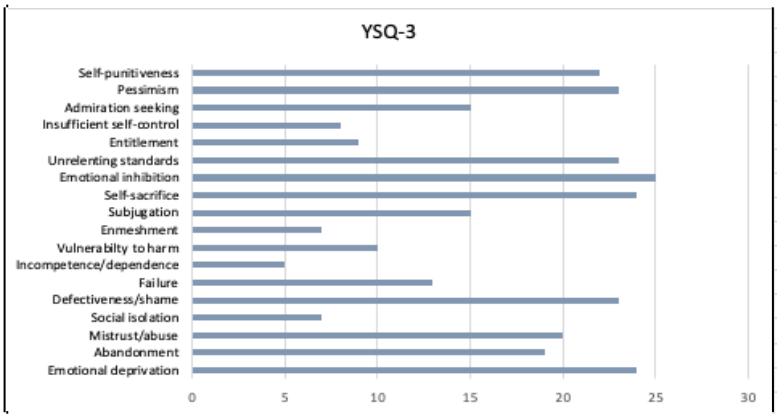
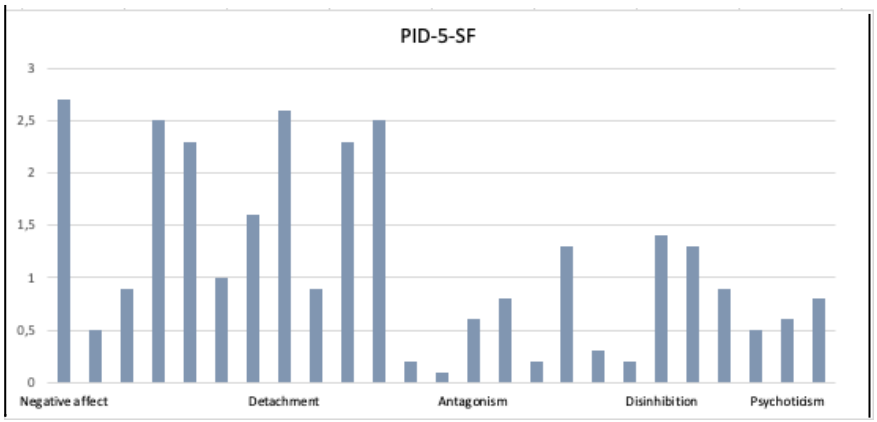


Figure 2. Personality Inventory for DSM-5.



Figures 1 and 2 show the patient's early maladaptive schemas revealed by the Young Schema Questionnaire (YSQ-S3; Young, 2005) and the personality domains measured through the Personality Inventory for DSM-5 (APA, 2013). The patient's patterns refer to early experiences of neglect, abandonment, and emotional deprivation, giving rise to a sense of being defective and deserving of self-punishment. The personality domains lie mainly on negative affectivity, which refers to emotional lability and difficulty regulating emotions, and detachment, which consists of a tendency to withdraw from relationships and avoid intimacy.

3. Therapeutic relationship: interpersonal cycles and impasses

The leading cause of the fracture in the therapeutic relationship is the separation that occurred between patient and therapist due to the pregnant state of the therapist. Indeed, starting from the idea of herself as unlovable, the patient feels the frustration of the aims of love, dignity, and security in the therapeutic relationship (Pugliese et al., 2023) as a consequence of the therapist's temporary absence. Even though the patient perceives the sense of loss as a state induced by the distance of the therapist, whom she imagines to be unconcerned about, she reacts with avoidance coping as she does not feel entitled and safe to express her suffering. Hence, problematic interpersonal cycles arise, whereby the patient acts in such a way as to elicit reactions in the therapist that confirm her pathogenic beliefs (Carcione et al., 2016). The three primary interpersonal cycles occurring in the relationship are described. The cycles are intended to alternate with each other during an impasse in the therapeutic process, lasting several months.

Deontological cycle (Deontological self/Humiliating other): In the face of the therapist's availability and attempts at closeness, the patient feels anger as she feels distrust and considers them inauthentic. She, therefore, begins to engage in critical and protesting behavior in the therapeutic relationship, controlling everything the therapist does and attempting to reverse the roles. The therapist, who has a similarly traumatic history, perceives the patient as abusive and reacts aggressively, confirming the patient's fear that the other despises her as unworthy.

Altruistic cycle (Altruistic self/Fragile other): Faced with the therapist's confinement reactions due to her attempts at resolution based on control and the use of power, the patient begins to feel guilty, identifying with the abuser. To atone for this sense of responsibility, the patient, who sees herself as a worthless burden to the therapist, begins to "help" her through her clinical skills. This behavior is guided in the patient by the idea that she can only obtain love and closeness when she plays the helper role. With this attitude, the patient arouses a sense of guilt in the therapist, who now feels a sense of inadequacy as she does not feel equal to the situation and identifies with the abuser. The therapist then proposes to the patient to turn to another therapist, confirming her fear of being abandoned because of her unlovability.

Mixed cycle (Deontological self/Humiliating other; Altruistic self/Fragile other; Vulnerable self/Abusing other): In the mixed cycle, the patient's mental states alternate chaotically with each other. She, therefore, feels guilty at the idea of creating further problems for the therapist (*Altruistic self/Fragile other*), feel unrecognized and unseen in her needs by her (*Deontological self/Humiliating other*), and feels that she can no longer trust her and cannot show her fragility because she feels that the therapist would not be able to support her (*Vulnerable self/Abusing other*). The therapist tries various interventions: she shows the patient the interpersonal cycle that had been developing to help her differentiate, communicates her difficulties in managing the situation, and reassures her through her presence and closeness. The patient experiences the therapist's differentiation as an attempt to push her away (*Deontological self/Humiliating other*), the sharing of her difficulties as empowering (*Altruistic self/Fragile other*), and her closeness as dangerous (*Vulnerable self/Abusing other*). At this point, the therapist experiences the reactivation of a new traumatic state, feeling powerless (*Vulnerable/Abusing other*), not up to the task (*Deontological self/Humiliating other*), and capable of harming the patient (*Altruistic self/Fragile other*). Faced with this shared mixed state, during the sessions, there were moments of silence and detachment where the only thing that emerged was a profound sense of helplessness.

The activation of the three traumatic parts leads to a complex mixed cycle that self-sustains over time, characterized by moments in which the patient's sense of devaluation is followed by the therapist's, the fear of harming the patient follows the fear of harming the therapist, and the patient's sense of danger is followed by the therapist's.

4. Disconnection as a cure

The resolution of the impasse occurs when the therapist adopts a reflective attitude that allows her to understand that what is active is not her mental state but that of her patient and that she is experiencing her own emotions. She realizes, therefore, that her activation can be observed and contained as countertransferential. The acquisition of a sense of control, constant presence even when the patient was

pushing her away, and transparency towards the patient led the latter to gain a more stable sense of security in the relationship. The patient slowly brings forth her vulnerable part, albeit marked by strong states of shame. The therapeutic relationship remains characterized by continuous dysregulation and co-regulation between the patient and the therapist. However, the patient no longer perceives these moments as irreparable and hopeless but as typical instances of disconnection that characterize a healthy relationship (Tronick & Gold, 2021).

Given the patient's ingrained distrust with a history of complex trauma, repairing the alliance is an ongoing process during treatment. It is, in a sense, analogous to the attachment development process between parent and child, where there is a transition from attunement to disruption and, finally, to repair (Steele et al., 2001). This process is crucial because it underlies the expectation that the relationship can be disrupted and subsequently repaired, allowing the patient to modify her traumatic schema.

A primary dynamic in trauma involves the representation of family roles as victim-perpetrators in the therapeutic relationship: the therapist and the patient embody these roles, often in complementary ways, reliving different aspects of the patient's attachment relationships. While the therapist's emotional identification with the patient's "victim" experience can be very painful, identification with the "aggressor" can take various forms and lead the therapist to rationalize, feel repulsion towards the patient's behavior, or become judgmental when the patient does not conform to how a "good" patient should behave (Herman, 2005). The traumatized patient carefully monitors the environment, developing a sophisticated ability to notice the non-verbal signals of others and attempting to resolve their ambiguity through interpretative bias, as uncertainty is intolerable for him/her (Arditte Hall & Arditte, 2022; Gebhardt et al., 2017). This hyperattention to signals from others' behavior necessitates the therapist to adopt an authentic and genuine attitude within the relationship, maintaining a good awareness of their emotions, needs, and origins to use them to understand and help the patient. On the contrary, any inauthentic behavior by the therapist leaves room for interpretations in the traumatized patient that align with their negative expectations and foster the establishment of dysfunctional interpersonal cycles (Carcione et al., 2016).

5. Conclusions

Insecure attachment can act as a risk factor in patients with complex trauma’s ability to establish a good therapeutic alliance, and this appears particularly true in cases of avoidant attachment (Lafrenaye-Dugas et al., 2018), where the development of interpersonal relationships is experienced as frightening and may lead to the denial of the need to establish a relationship with the therapist (Smith et al., 2010; Godbout et al., 2017). Survivors of early exposure to relational trauma often hold a predominant belief about the world and others as dangerous and uncaring, while on themselves, the belief of deserving abuse and suffering prevails. Patients of this kind are not quickly drawn to the therapist's empathy and warm welcome; instead, such attitudes can elicit a response of increased distrust, intense dysregulation, and hostility (Courtois & Ford, 2012). Dysregulation leads to chaotic and alternating mental states and withdrawal responses, and even the most experienced therapist can become the object of the patient's negative projections.

A patient coming from a family system based on abuse or neglect inevitably leads to the development of insecure dependence since secure or "healthy" attachment is either never constructed or destroyed. In the therapeutic relationship, the patient will, therefore, experience profound needs for dependence and attachment stemming from their life history, often described as intolerable and incessant. The therapist should seize the opportunity to support the patient regarding past sufferings and provide hope for the present, where there is help and secure attachment (Steele et al., 2001). When memories related to trauma are evoked, the patient feels a sense of threat, and manifestations of a fear state can be expected in the relationship with the therapist. The fear of being in the relationship can take the form of an exaggerated perception of potential abandonment, blame, feeling repulsive, and, consequently, "contaminating" the therapist. The patient may experience unbearable fear in the face of any minor disruption in the therapeutic relationship, such as a change in an appointment or a lack of response from the therapist. Like a child facing the mother's still face in the Still Face experiment, the patient struggles to make sense of that experience (Tronick & Gold, 2021). In response to this, the therapist should be able to provide a secure relationship through strong emotional attunement and commitment to repairing the relationship whenever an attachment interruption occurs (Dalenberg, 2000; Fosha, 2000). The therapist must restore emotional balance and tolerance in the face of the patient's push-pull tendencies, their dysregulation, and the risk of retraumatization resulting from attempts to elicit rejection from the therapist, sometimes with conscious intentions and sometimes not. As the patient gains security, insecure dependence is gradually replaced by a more secure dependence, and interdependence and autonomy emerge (Steele et al., 2001).

In light of this clinical case, it is possible to conclude that maintaining a good reflective competence and integration for the therapist in the relationship with the traumatized patient increases their

therapeutic self-efficacy and empathy. During moments of incredible difficulty this may help to preserve the authenticity of their relationship, and serves as a role-modeling for the patient who may finally feel worthy of expressing authentic parts of themselves. It also allows the therapist to rebuild the trust lacking in the patient's history, forming the foundation of a healthy, dependent relationship.

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