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BOOK REVIEWS:

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The International Journal of Psychotherapy is a leading professional and academic publication, which aims to inform, to stimulate debate, and to assist the profession of psychotherapy to develop throughout Europe and also internationally. It is properly (double-blind) peer-reviewed.

The Journal raises important issues in the field of European and international psychotherapy practice, professional development, and theory and research for psychotherapy practitioners, related professionals, academics & students. The Journal is published by the European Association for Psychotherapy (EAP), three times per annum. It has been published for 24 years. It is currently working towards obtaining a listing on several different Citation Indices and thus gaining an Impact Factor from each of these.

The focus of the Journal includes:

- Contributions from, and debates between, the different European methods and modalities in psychotherapy, and their respective traditions of theory, practice and research;
- Contemporary issues and new developments for individual, group and psychotherapy in specialist fields and settings;
- Matters related to the work of European professional psychotherapists in public, private and voluntary settings;
- Broad-ranging theoretical perspectives providing informed discussion and debate on a wide range of subjects in this fast expanding field;
- Professional, administrative, training and educational issues that arise from developments in the provision of psychotherapy and related services in European health care settings;
- Contributing to the wider debate about the future of psychotherapy and reflecting the internal dialogue within European psychotherapy and its wider relations with the rest of the world;
- Current research and practice developments – ensuring that new information is brought to the attention of professionals in an informed and clear way;
- Interactions between the psychological and the physical, the philosophical and the political, the theoretical and the practical, the traditional and the developing status of the profession;
- Connections, communications, relationships and association between the related professions of psychotherapy, psychology, psychiatry, counselling and health care;
- Exploration and affirmation of the similarities, uniqueness and differences of psychotherapy in the different European regions and in different areas of the profession;
- Reviews of new publications: highlighting and reviewing books & films of particular importance in this field;
- Comment and discussion on all aspects and important issues related to the clinical practice and provision of services in this profession;
- A dedication to publishing in European 'mother-tongue' languages, as well as in English.

This journal is therefore essential reading for informed psychological and psychotherapeutic academics, trainers, students and practitioners across these disciplines and geographic boundaries, who wish to develop a greater understanding of developments in psychotherapy in Europe and world-wide. We have recently developed several new 'Editorial Policies' that are available on the IJP website, via the 'Ethos' page: **www.ijp.org.uk**

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The IJP Website: www.ijp.org.uk

The IJP website is very comprehensive, with many different pages. It is fairly easy to negotiate using the tabs across the top of the website pages.

You are also able to subscribe to the Journal through the website – and we have several different 'categories' of subscriptions.

You can also purchase single articles and whole issues as directly downloaded PDF files by using the Catalogue on the IJP website. Payment is by PayPal. We still have some printed copies of most of the Back Issues available for sale.

Furthermore, we believe that **'Book Reviews'** form an essential component to the 'web of science'. We currently have about 60 books available to be reviewed: please consult the relevant pages of the IJP website and ask for the books that you would enjoy reviewing: and – as a reviewer – you would get to keep the book. All previously published Book Reviews are available as free PDF files.

There is also a whole cornucopia of material that is currently freely available on-line (see the top left-hand corner of the website). **Firstly**: there are several "Open Access" books available, free-of-charge; **next** there are an increasing number of free "Open Access" articles; **then** there are a couple of articles available from the forthcoming issue, in advance of publication.

There is also an on-going, online 'Special Issue' on **"Psychotherapy vs. Spirituality"**. This 'Special Issue' is being built up from a number of already published articles and these are available freely on-line, soon after publication.

Finally, there are a number of previously published **Briefing Papers**. There is one on: *"What can Psychotherapy do for Refugees and Migrants in Europe?"*; and one on an important new direction: *"Mapping the ECP into ECTS to gain EQF-7: A Briefing Paper for a new 'forward strategy for the EAP."* Because of a particular interest that we have in what is called by "Intellectual Property", we have included a recent briefing paper: *"Can Psychotherapeutic Methods, Procedures and Techniques" be patented, and/or copyrighted, and/or trademarked? – A Position Paper."* Lastly, as part of the initiative to promote psychotherapy as an independent profession in Europe, we have: *"EAP Statement on the Legal Position of Psychotherapy in Europe"*, which we published in a recent issue.

International Journal of Psychotherapy

Editorial

Courtenay Young

Editor, International Journal of Psychotherapy

Dear **Readers of** – and **Subscribers to** – the **International Journal of Psychotherapy** (IJP),

We enter into our 26th year of publication as the EAP celebrates its 30th Anniversary (albeit slightly belatedly). We have all come a very long way since the "Strasbourg Declaration on Psychotherapy" was – allegedly – mapped out on a table napkin in a bar in Strasbourg in October 1990: perhaps Alfred Pritz, its instigator, will give us more details during our celebrations this Spring. Just as a reminder to our readers, here it is:

> *In accordance with the aims of the World Health Organisation (WHO), the non-discrimination accord valid within the framework of the European Union (EU) and intended for the European Economic Area (EEA), and the principle of freedom of movement of persons and services, the undersigned agree on the following points:*
>
> 1. *Psychotherapy is an independent scientific discipline, the practice of which represents an independent and free profession.*
> 2. *Training in psychotherapy takes place at an advanced, qualified and scientific level.*
> 3. *The multiplicity of psychotherapeutic methods is assured and guaranteed.*
> 4. *A full psychotherapeutic training covers theory, self-experience, and practice under supervision. Adequate knowledge of various psychotherapeutic processes is acquired.*
> 5. *Access to training is through various preliminary qualifications, in particular human and social sciences.*

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As we continue to adapt and adjust to the changing world situation to the threat of war in Europe, the numerous on-going conflicts in many countries in the world, the climate crisis – that will probably affect our children and grandchildren more than us, the on-going pandemic that will not go away until it is treated globally, and personal tragedies and crises that impact on us and our clients, let us consider what we – as psychotherapists – can do to help. The UKCP, the national organisation for psychotherapy in the UK, recently published a number of articles on children's mental health.[1] Not many of us work with children, yet this is one of the best predicators for reducing the increasing mental health issues that also plague our society. What else can we do – with our adult clients – to ensure that their mental health improves? Please look at some of the research literature that is coming out now about how to work more effectively as a psychotherapist. I hope to be publishing an article (a literature review) on this in the next issue.

We might also want to consider how to work more effectively with those amongst us in real need, so that we really begin to raise the bar in our society in mental health terms: the homeless, refugees, prisoners, the poor, the abused, etc.: these are the people in the greatest need of help and where 'change' means that the person becomes someone who can now contribute towards general well-being. There is also a lot more material becoming available nowadays on how to work more effectively with people who have been traumatised. Much of this information and material was probably not available when we trained originally as psychotherapists: so, are we all totally up-to-date and fulfilling our CPD requirements? I would like to suggest that there can – always – be more to learn. Certainly, some of the articles in this issue will therefore be of interest.

Our first article is by an eminent Swedish psychiatrist, **Dan Anders Palmquist**: the article is entitled, *"When Our Soul Has a Life of its Own": An Extended Essay on Dissociation*. It is an exceptional article, of much more than the usual length, yet – because of its uniqueness – we decided to break the 'rules' and publish it anyway. It reflects on – and is a reflection of – a lifetime's work with traumatised people, often dissociative, who almost certainly need a different approach than the traditional ones. This implies a different understanding of dissociation.

Many different aspects of such cases are described in a very personal account of his work with such clients, offered in a number of vignettes (rather than full case histories). He examines the reactions of traumatised people and then looks at how to make contact with such people and how to help them to move out of their dissociated, traumatised states. Some of you may not agree with the inclusion of the 'soul' into his medical, psychiatric and psychotherapeutic work, but – after all – we are supposed to be dealing with the 'psyche' (Greek for 'soul'). I am sure that we can all learn from this article: I certainly did!

Our next article is the third article in a series from **James C. Overholser** on *A Pragmatic Framework for the Supervision of Psychotherapy*, subtitled *Socratic Exploration*. He states: *"The supervisory process relies on a systematic series of ques-*

tions to guide a collaborative search for ideas that can result in a refined strategy for therapy" – and this is what he explores in this excellent article.

This is followed by a short article, *Screen Relations in Practice – A Reflection on Rupture and Repair*, by **Ronen Stilman**, which looks at how our relationship with technology shapes our perceptions, especially when working online, and he offers some practical examples that explore what can be gained by paying attention to some of the new information available.

Next, we have another article from **Marc Tocquet** [2], this time with **Jennifer Dennis** and **Caroline Winkopp** entitled, *Therapeutic Process & Transference in Psycho-Organic Analysis*. This is a modality that sits between Body Psychotherapy and Psychoanalysis; and this article explores the therapeutic process and transference with reference to bodily sensations, feelings and emotions.

One of our regular contributors, **Richard G. Erskine**, provides the next article, *Relational Withdrawal, Internal Criticism, Social Façade: Psychotherapy of the Schizoid Process*. He makes a distinction between schizoid style, pattern and disorder and explores some of the concepts, like psychological 'splitting' of different sorts. He describes, in some detail, a case example that demonstrates some of these aspects.

Our sixth article, from the United States, looks at the literature about how psychotherapeutic interventions – specifically music and art therapy and a self-awareness scale can have a positive impact on adult cancer patients. The effects of hypnotherapy, Cognitive Behavioural Therapy and meditation ere also analysed. It is entitled, *The Success of Psychotherapeutic Interventions in Enhancing Welfare in Adult U.S. Cancer Patients*, by **Ruby Dagher**, **Carine Kabbara** and **Ibrahum El Tannir**, 3rd-year students from the Faculty of Arts & Sciences at the American University of Beirut. We welcome them! Whilst this article has a distinct medical-treatment orientation, this provides an interesting perspective that the psychotherapeutic (non-pharmacological) interventions are possibly more able to be measured and researched. Its conclusion was that there are improvements in multiple symptoms, including better mental health, reduced pain sensations and feelings of self-worth and confidence. It also looks at some of the secondary effects, such as prolonged life, a speedier recovery and a reduction in their stay in hospital.

We then progress to a couple of tributes – memorials to David Boadella, whose passing was announced in the last issue of the Journal. There have been masses of these submitted after a memorial service (via Zoom) in mid-January. We are only publishing two here: one a recent interview made with a Greek colleague, **Lily Anagnostopoulou**;[1] and the other containing some personal memories of a

1. Re-printed from the *International Body Psychotherapy Journal*, 20, 1, pp. 8-10, with the kind permission of the IBPJ Editor.

life-time's work with him from a UK colleague, **Tricia Scott**. All the other tributes will be published together soon, separately.

Finally, we have 3 book reviews, which I hope you will enjoy.

Endnotes

1. *The New Psychotherapist*: No. 79, Spring 2022.
2. Tocquet, M. (2019). What is Psycho-Organic Analysis? A description of the therapeutic space between body & psyche. *International Journal of Psychotherapy*, Vol. 23, No. 1.

‘When Our Soul Has a Life of its Own’: An Extended Essay on Dissociation

Dan Anders Palmquist

Abstract: This paper is an attempt to illuminate the tendency in humans to react with dissociative strategies, especially when confronted with overwhelming psychological and physiological stimuli, in particular abuse and traumatic situations. This, I will try to do by presenting a variety of vignettes from therapeutic encounters, most of them taking place during the 1970s and 1980s – as well as discussing the concept of trauma and related topics in the light of newer neurological findings, such as the Mirror Neuron System. [1]

Key Words: Dissociation, Trauma, Affects, Defence-Mechanisms, Dissociative Identity Disorder, Repression, Incest, Abuse, Mirror Neuron System, Hypnosis, EMDR

Part 1

How can it be that the concept of trauma (Greek for “wound”) is so prevalent in the contemporary discourse? How can it be that so often it is only revealed as various types of abuse, from the ill treatment of children, incest, rapes, people shot in connection with crimes, war zones and other sundry miseries? When I began my career as a young psychologist at a big mental hospital in Sweden in the late 1960s, I had almost never heard anything about sexual abuse. Besides the “classical” diagnoses, you could find a rising prevalence of substance abuse, psychoses (caused by hashish), and youngsters who had “sniffed” themselves into mental disturbances – but little else.

So, you might think! I remember the patient, who bit everyone around her, who had made herself quite impossible at school, who either cried rampantly, or became mute, not wanting to go home on the limited number of leaves. Never ever was there a single thought from the officials, or conclusions drawn by reading her journal entries, that there might be something totally – horribly – wrong in her home envi-

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ronment. Or the patient, who regularly went AWOL in order to prostitute herself, much to the horror of the staff. Behaviours like these were considered as 'aberrant' symptoms, possibly remediable by medication.

Having eventually met both of these patients, as well as several others in long-term psychotherapeutic situations, I know, today, a lot more about the mechanisms that can obstruct the knowledge of what has happened. But the questions remain: 'Why now?' Could it be that somehow this is related to the heavy features of alienation, on the one hand, and the vulnerability and fatigue syndromes on the other? Or – stating this in psychological terms – the pathological narcissism that seems to arise, along with self-importance and insensitivity that leads to the great vulnerability. It becomes closer: the misery of the world.

So, this self-analysis was written: a long time before "Me-Too"; a long time before the exploding atrocious violence manifested by ISIS; a long time before the terror bombings amongst civilians; before devastating shootings on open streets; and long before the massive flow of refugees across the European continent. But, maybe this is the time that we should be prepared for, having developed all the necessary tools so as to help victims? Or ... what?

Trauma – Definitions

The flow of refugees (as I wrote 2003), in which there is an abundance of people who have had outrageous experiences of war, torture, violence, rape and other horrors, brings to the fore questions of what happens to a person who has been suddenly subjected to something totally beyond his or her 'normal' capacity to endure: a totally non-predictable course of events; possibly even becoming a threat against one's survival; giving rise to intense psychological and physiological pain.

Henry Krystal (1988) presented the idea that – when a person is confronted with overwhelming affects – these emotional reactions induce an intolerable psychic state, threatening to tear down, or even destroy, psychic functions: like the fear of dying, dissolving; or resembling the anxiety of schizophrenics; or the psychosis acting as a defence – which is the first part of the traumatic process.

This initiates a series of subconscious, detrimental reactions – constituting the traumatic syndrome. The horror of the adult person might be interpreted as a re-enactment of the absence of the mother, when she was most needed. Krystal holds that the overwhelming affect is destructive, because it represents a para-sympathetic stimulation resulting in lack of coordination. When the subjective evaluation of a certain situation tells us that the chances of surviving it are going to be hopeless, the emotional state is transformed from anxiety into catatonic reactions, yielding more blocking reactions. Survivors of (for example) the "Estonia" catastrophe [2] tell of passengers sitting frozen, not doing anything to rescue themselves, whilst the survivors literally having to force their way out.

Traumatizing, according to Krystal, takes place when the ego turns helpless during an indefinite period of time, where alleviation is lost sight of, and the 'victim' will have to surrender themself to what is perceived as an inevitable danger, stemming from the outside or from within.

David Spiegel (in: Kluft, 1999) defines trauma as "*the experience of being made into an object; to be the victim for somebody else's rage, powers of the nature or one's own physical or psychological limitations*". Besides the pain and the anxiety that goes with rape, war-trauma or whatever cataclysm comes along, there exists a barely endurable sense of impotence, a realization that one's own will or wishes will

not suffice, no matter what. The result is: either, a feeling that the self has been damaged, been contaminated with humiliation, pain and fright; or, that it simply dissolves.

Why do we have to protect the soul?

... (and, by doing that, the body). Some specific mechanisms of defence – looked upon from a traditional point of departure, include Freud's first theory, which stated that psychic disturbances were the consequences of the 'child' being exposed to something that exceeded its ability to cope using the functions of the ego. He considered two models: one was unbearable situations, like shell-shock; the other situations, with a so-called dynamic pathogenesis meaning that the situation acquires a traumatizing meaning, like *"Mommy is not here; she has left me for good, because of my conduct"*.

A basic ingredient in psychic disturbances is said to be a lacking ability to choose on one's own. Otto Fenichel (1945) writes: *"All neurotic phenomena are based on insufficiencies of the normal control apparatus"*; also:

> *The insufficiency can be brought about in two ways. One way is through an increase in the influx of stimuli: too much excitation enters the mental apparatus in a given unit of time and cannot be mastered; such experiences are called traumatic. The other way is through a previous blocking or decrease of discharge which has produced a damming up of tensions within the organism so that normal excitations now operate relatively like traumatic ones. These two possible ways are not mutually exclusive.* (p. 19).

In this model, lacking ability of the individual to cope with the emerging impulses from the subconscious, paves the way for difficulties. *'Repression'* should be understood within this context. Through a subconscious contribution of energy, the *Ego* prevents a drive-impulse and/or its derivative becomes conscious, or stays in the consciousness. The discharge of the impulse is completely inhibited as *repression* is the only, or the main, defence against a given impulse. Most defence mechanisms of the so-called "Ego defences", protects the Ego against the signal anxiety, arising due to the conflict between impulse and *Superego*.

Freud looked upon repression as a kind of *"unintentional not-thinking at some goal"*. It was supposed to be the effect of certain memories, but not of others. Freud and Breuer (1893) said that hysterics suffered from reminiscences. *Repression* is the English translation of the German *Verdrängung* – literally to "push away". Freud (1915) stated that the essence of *repression* was that something was turned away, and/or kept at a distance from the conscious. The reason for this was to avoid something disturbing, thus *repression* is a motivated act. However, Freud remains unclear if this was performed subconsciously or consciously. His daughter, Anna Freud, considered this was a sub-conscious act; the impulse might be conscious for a very short period of time. *Repression* should produce amnesia for the so-called "declarative facts", but not for the "procedural facts" – meaning that you could remember *what* happened to you, but *not how* it happened.

"Poor Schreber" (Freud, S., 1911) is offered as an example – he had bodily memories of his father's terrible correctional gadgets, but he did not remember them as the tools of oppression that they were. The present author wonders about Schreber's paranoid fantasies: – are they developments of already known themes; or are they newly designed? Did Schreber suffer from flashbacks: or was it PTSD?

Schreber's paranoid delusions might have been some form of attempts to understand the

return of traumatic experiences; not excluding the drive/impulse/conflicts. We should not therefore rule out projection-type mechanisms, suitable when it comes to help the soul to externalize terrible thoughts and affects. Doing so, things get worse, thus making the world around menacing. But did Schreber remember what took place between him and his father? The fantasies of torture, which terrorized him: what did they represent? '*Repression*' singles out the drive-impulse/derivatives, meaning not only does it take away the impulses, but also the thoughts, which are exiled to the (secondary) subconscious. '*Isolation*' comes to mind, preserving the thoughts, but not the affects. Below, I will present two case vignettes illustrating the range of dissociative reactions. Later on, I will discuss in more detail, dissociation and related significant.

Case Vignette 1

A middle-aged patient, who is seeking contact, tells me – at the initial interview – that she suddenly gets nightmares, in which she is exposed to different sexual acts by a man. The man reminds her of her father. Feelings of shame, disgust, that is to say strong negative feelings (Tomkins, 1991). *She does not understand – hence, fearing that she is losing her mind.*

Her life history presents a woman living an ascetic, not to say anorectic life. Divorced since her husband had cheated upon her – then she had some relationships with men, always feeling that she had to "support" their sexual demands. She had seen a lot of therapists, because of a "flickering" spark of life, i.e. a depression. The latest therapist seemed to be completely unrestrained at the beginning and then had simply abandoned her. Fantasies? Constructions? Or variations of the known, but unthought? Return of the repressed? Different Ego States? Dissociation?

During her treatment, we discovered incidents of incest, corporal punishment, humiliation.

Case Vignette 2

At a basic course of hypnosis, taken years ago – I was one of the teachers – the group was given the suggestion to go back one week in time, by thinking, "What did you have for dinner yesterday / or the day before yesterday" … and so on. One of the participants had suddenly started to cry; became agitated; was given suggestions to go even deeper; to integrate the experience; and if she wanted to, tell us everything afterwards. In her waking state, she was very surprised over her reaction and its intensity. Then, she told us that one week ago she had been involved in a car accident – at that time, not reacting at all.

Is the reaction postponed? Repression? Dissociation? Or a reaction of this kind is not at all uncommon; often, such reactions emerge when the dust has settled, many times as surprising to the person in question, as to the human environment. However, when our memory fails us, we tend to reconstruct and these falsifications (says Freud 1899) serve repression – often by substituting appalling or disgusting impressions.

Denial (German: 'Verneinung') is a defence mechanism that helps us to avoid impressions that are too strong, impressions that might cause unease, thereby stimulating impulses ending in conflict and anxiety. In this process, the Ego strives to counteract a perception characterized by discomfort, via a wish-fulfilling fantasy, or via a behaviour-designed-in order to show that the aforementioned perception does not exist.

At the end of his life Freud again got interested in this phenomenon: "*It is the defence mechanism of denial, the ability not to recognize or not fully to recognize certain data of reality*"

(in Fenichel, 1942). According to Freud similar mechanisms occur in normal people: *"In normal people it presupposes the simultaneous effectiveness of another mechanism, a certain cleavage of the ego (Ichspaltung / Splitting of the Ego)"*. Specifically, Freud here speaks of *"a child whose experience creates the conception that a certain instinct satisfaction may be dangerous, may defend itself against this danger and simultaneously deny the existence of the danger altogether"* concluding that *"a part of his ego knows; another part of his ego does not know"*.

Could it be that Freud here somehow returned to the discussion of dissociation? When extrapolating these thoughts, one may end up in the concept of Ego States (Watkins & Watkins, 1997). The Watkins couple maintain that their 'Ego state theory' links normal personality functioning with its extremes, such as found in dissociative identity disorder".

A Classical Case

Little Hans (Freud, S., 1909) was afraid of his father, who was a rival for his mother, but he repressed his anger, instead becoming afraid of horses. But poor *Little Hans* still longed for his mother, a longing that became threatening, thereby making him even more frightened of his father, the more he longed. How to cope with this? *Repression*; *Postponement*? However – something / someone seldom mentioned that it was poor *Little Hans*, who was probably more afraid that he might be left alone. As I understand the story, he feared that his parents would eventually divorce, which they finally did. Reading between the lines, we find that *Little Hans* was spanked a lot by his mother – in all, making it really difficult to understand what kind of anxiety was at the fore! In the classical conflict model, this is all about the drive impulses.

A "Not That Classical" Case

Another example might be the situation in which a big 'crash' announces that Mommy's favourite 'show-piece' vase or tea-pot has ceased to be. The rapidly approaching parent then perceives, close to the debris, a small child who as quickly says, *"It wasn't me!"*. If the parent insists on an explanation, then the child turns anxious, providing increasingly eerie explanations. Better, ego-functions were displayed by the little boy, who during the 1940s, was sometimes sent to buy milk, bottled in glass; upon returning and about to climb the stairs, he drops the bottle. The parents, hearing this, opens the door upstairs, only to hear the injured little boy exclaiming: *"Why did you send me to buy milk, me being so bl---y tiny"*. Irrespective of joking, how do we explain the anxiety of the first child compared to the second? Could this emanate from an anger towards the parent, giving rise to a sub-conscious wish to tear down the "Mother" from her pedestal; so, the second child could not stop the impulse? If so – how do we discover repression? *Acting out*? *Denial* – it might be the defence towards the discomfort instigated by the parent.

One might presume that the child knows that he is going to get a form of corporal punishment. What kind of anxiety will emerge? The uprising, angry impulse to defend oneself? Anxiety from the fear of losing the love of the parent? Anxiety expecting psychic and physical pain? How can a child differentiate between these alternatives and what kind of authentic defence is mobilized? Also – we should note that the state of the ego functions plays a significant part in the 'drama'.

Case Vignette 3

> *The patient, being in long-term therapy, 4-5 times a week, one day literally danced in through the door, in high spirits, wanting to*

> *sing and dance a pop song to me, the title was something like "Let's go visibly explore our corporal geography". She performs the song and dances in front of me, the speechless therapist, then hurls herself, lithely, in the armchair, looking happily at me, and then talks/rants about the song so intensively that nothing else can be added. When the session was over, I was left bewildered. In the next session, the patient arrives in a completely different mood, lets herself sink down and remains quiet. I bring up the previous session – the patient is completely blank! My feeling was that the patient did not forget – she was not able to say, "No I don't remember". The question was simply irrelevant to the patient. My impression was that the person that I was speaking to then had not been 'present' in the preceding session!*

An Effort at Interpretation

Four years had gone by in this client's therapy, 4-5 times a week, and my patient was on the verge of getting into the abuse that she had suffered: abuse that had been confirmed by several sources – her journey through the "system" had begun 13 years earlier. When I first met her in 1970, there was no real concept of abuse, in spite of child psychiatry, youth psychiatry, etc. As far as I could understand, there was nothing else, other than the (therapeutic) process itself and the therapeutic relationship – nothing that could motivate the song-and-dance performance: it was – just – a spontaneous emergence of a new aspect of her personality.

The Classical View

What does Freud have to tell us about cases like this? We have to immerse ourselves in *Studien über Hysterie* [*Studies in Hysteria*], written during the years 1893-95, in collaboration by Freud and Breuer:

> *The splitting of consciousness, which is so striking in the well-known cases of double conscience, exists in a rudimentary fashion in every hysteria and that the tendency to this dissociation-and therewith to the production of abnormal states of consciousness, which may be included under the term "hypnoid" – is a fundamental manifestation of the neurosis".* (p. 44)

Breuer also tells us about "Anna O", in that:

> *"She had two completely separate states of consciousness, which alternated quite often and suddenly, and, in the course of her illness, became more and more distinct. In one state, she was sad and apprehensive, but relatively normal. In the other state, she had hallucinations and (apparently) "misbehaved", that is, she swore and threw pillows at people, etc.".*

Dissociation

In 1889, Pierre Janet published his doctoral thesis, *"L'Automatisme Psychologique"*, presenting other ideas, many ignored by traditional psychoanalysis. His point of departure was that behavioural patterns were always characterized by both subconscious *and* conscious components. Today, we find this a truism. Imagine walking upstairs! Most of the time, we do not use our thoughts in order to move our legs – although, when we are feeling a bit unstable, we probably do. Having conquered a difficult passage when playing the trumpet, once, when in the middle of it, I became conscious of the swift movements of my fingers, immediately causing me to come to a complete standstill.

Another common example, when driving a car, we may allow our thoughts to drift – suddenly we begin to wonder, *"Did I really pass X – as I am now approaching Y"* – the classical 'highway hypnosis'. So, we can find ourselves in

different states of consciousness – also this is, in itself, a truism in modern hypnotic research.

"Dissociation refers to a wide variety of behaviours that represent lapses in psychological and cognitive processing" (de Zulueta, in Sinason, 2011, p. 101). *Amnesia*, *absorption* and *depersonalisation* are the main symptoms. *"Absorption implies becoming so involved in what you are doing that you are unaware of what is going on around you"*. Depersonalisation may be described as the tendency to experience events – as if one is a mere observer; an estrangement from one's self. Often, this is accompanied by emotional 'numbing'.

Behavioural patterns, when becoming dissociated, are **not** being regulated by normal personality systems (according to Janet), but by – at that time – badly understood concepts of a multi-dimensional system of regulation with complicated feedbacks, all in the service of a bigger system: that is they are being regulated by the whole organism. This might be understood as an adjustment process in the service of survival. The unconscious should not be seen as a 'dumping-ground'; however, the sub-conscious, as a gradually refined protective system, eventually becomes functioning quite automatically. Every time that something takes place that exceeds the individual's ability to cope, at that very moment, this automatic 'inner help' is activated – with their ability to dissociate being crucial.

According to the modern definition (Bob, P., 2003, p. 903) *"dissociation represents a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness"*. Please observe that *splitting*, *keeping apart*, is not what is meant. Kernberg's (1975, p. 165) definition of 'splitting' is the most commonly used one: *"Splitting refers to the active, defensive separation of contradictory ego states"*: an upholding of different systems of identification having opposite valence.

The 'drive' derivatives, having fully conscious, emotional, ideational (cognitive), motor components, become separated from other segments of the person. The conflict is thus often between introjections "with opposite valence" (like 'good' and 'bad'). However, Kernberg (1975) also talks about "primitive dissociation". Later on, *repression* comes at the fore, at the expense of requiring more "energy". We have already stated that *repression* takes away the drive impulse and its derivatives (fantasies, thoughts). Observe that *dissociation* does not deal with drives and derivatives, but with different states of experiences. Commonly referred to as *'ego states'*; but maybe "self-states" would be a more apt denomination? Keeping a distance between these introjections lends itself to so-called "primitive defences", such as idealization, primitive self-destructiveness and denial.

Already Paul Federn (1952) had talked about *ego states* meaning, *"inner patterns of behaviours and experiences being invested with a sense of Self, having a varying degree of independence"*. One common example might be what happens in connection with immigrants: the previously used language was spoken at home and old habits and "mores" were the same; but, in the outer world, a new language is evolving as well as other mores. The new language gradually becomes the "executive" one.

Another everyday example of dissociation can be observed at funerals. Close to the coffin, in church, we can cry deeply, but we can be heard laughing an hour later at the funeral feast; often you hear someone saying, *"This feels kind of unreal"*, referring to the awareness of both moods being so close together in time. The crucial variable here is the permeability between the different ego states. We may get as sad again, just like that, by having contact with the ego-state carrying the sadness – but – in rare cases, that state can be wholly unfamiliar, having its own life. Imagine yourself pointing

out to the person laughing, *"30 minutes ago you were crying deeply"*, then getting a bewildered, *"What do you mean?"*.

One reason behind Freud's – and later, the psychoanalytical movement's – disagreement of the dissociation model was because it, in a way, runs contrary to the 'drive' theories, that is the conflict model, based on drive impulse disturbing the *ego* and the *super ego*. To my way of understanding, dissociation is easier to comprehend using the theories of affect, and the feelings of Self (Stern, 1995). A multi-dimensional approach, which also includes the conflict model, might be the best point of departure.

When We Face Something Overwhelming

If we end up in a situation that is initially exceeding our ability to cope over a too-long period of time, we can end up in a situation of frustration. The 'affect-model' of Tomkins (1991) (also in Demos, 1995) facilitates such an understanding. An ability to integrate becomes mandatory – making it possible for the individual to add experiences, while not getting stuck in a rigid and monotonous pattern, unable to change course: this is a kind of a capacity of the soul for simultaneous processing. In Janet's view, the width of the attention span differs between individuals. He insisted that strong feelings, such as fear, played a significant role in traumatic events. The fact of the matter is that he differentiated between emotions, which he considered as regulating behaviour, and emotions (such as extreme fear and anger) making the individual unable to perform normally well-adjusted acts. Any pent-up energy is let out in such chaotic acts. Strong, violent emotions have a dis-integrative impact on one's wits. Stated today, such disrupted behaviour is often an indication of PTSD.

The Importance of Affect

The 'affect', or the affective colouring, constitutes the basis for sorting out our experiences. According to Damasio (1999), the 'affect' is what makes us aware of the world. Well-known in clinical hypnosis is the concept of the '*affect-bridge*' – meaning that, guided by an affect, you may walk along a bridge over troubled waters, meeting various situations connected by the same affect, albeit with very different content. You may conceive of a book of experiences with headings such as "situations in which I have been sad, or frightened, or feeling "blue" etc. Viewing a certain video, wherein the theme is (say) a little child being bullied, may elicit a sudden rush of anger, sadness etc. and a string of pearls of memories of such situations, quite unexpectedly!

Also, Piaget taught us that age determines what kind of thinking is possible. A 12-year old thinks in different way than a five-year old, about any certain given situation.

Fundamental, in my opinion, is the intensity of the affect. If bigger than the ego's coping capacity, the individual is brought into an *Alternative State of Consciousness* (*ASC*) because the 'affect' in question dominates the field of attention (compare this with Damasio, 1994, p. 189).

Speaking of Tomkins, we might say that the affect also is analogous with what is happening; the drama that is taking place around us has its counterpart inside of us, meaning that we, in all of our senses, are exposed to the total situation. If situations resembling this one are repeated, and if they are manageable, they will become linked together into a 'coping' pattern.

If they are extraordinary, and the individual has the capacity to dissociate, they might get linked together differently – thus forming '*alters*' – states of self that are created solely in order to cope with some (or a series of) overwhelming situations or aspects of such. This amounts to

a form of pathological dissociation. In the next paragraph, I will deal with an extremely vital variable that is closely related to our ability to cope with affects – namely the attachment.

Dissociation and Attachment

Along with recent discoveries concerning the neurological basis of dissociative processes, findings indicate that disturbances of the attachment process may constitute significant factors in the development of dissociative defence strategies. As we all know, Bowlby's (1973) studies on the effects of separation provided the groundwork for attachment theory. A loss of the 'Significant Other' is bound to have devastating consequences for the child.

Liotti and Main (in Sinason, 2011, p. 24) *"conceived the disorganised/disoriented pattern of attachment as predisposing the child to dissociation as a defence"*. When growing up without a secure base, the child will find him/herself lacking the emotional containment that a parent should provide. Findings (viz: Fonagy in Sinason, 2011, p. 25) indicate that emotional problems, such as depression in the mother (thus making her emotionally unavailable) may lead to disorganised attachment patterns. In families where the parents (one or both of them), are emotionally unstable, or – for some reasons – not emotionally available, the very process of building up a 'theory of mind' or a 'construct' may thus become jeopardized. The child ends up literally 'lost' in their social space. Furthermore, we now know that a situation where the parents are finely attuned to their child also is fundamental for the development of the brain (Gerhardt, 2004). It seems to be *"the very process of assigning words to affects that makes it possible for the left and the right brain hemispheres to become integrated"* (p. 67, re-translation by the present author).

The research that is building on the 'Still Face' phenomenon (Tronick, 1975) has elucidated the enormous significance of the mother's ability to stay finely attuned to the baby. An infinite series of emotional interplays paves the way for a 'theory of mind': predictability is indispensable. This is a *"simultaneous and synchronous dance"* (Tronick, 2021). Failures amount to a *"psychic catastrophe"*. Consequently, disturbances in this process may lay the ground for later inabilities, both in coping with emotions and the sense of being able to make an impact onto the world, that means that one loses – or never attains – one's sense of 'Agency' (Ackerly, 2012). Stern (1995) advocates that the development of a sense of 'Agency', that is to experience that one is the originator of one's own acts, is crucial for the establishment of a healthy Sense of Self.

The desperate need for the Significant Other is based on this: we need help surviving, interpreting, labelling our feelings and getting help to contain them; in short – for the establishment of an 'Inner World Model' (Elliot, 2021). If there is no Significant Other at hand, there is a fairly certain risk of the child becoming traumatized; it ends up with an infinite number of shortcomings where unmodulated emotion hampers the development of cognitive functions. Of course, the severity of this depends on a number of factors such as: the inborn stability of the 'system'; the frequency of failing attunement on the part of the Significant Other; the number of 'critical' moments; – and so forth. The absolute 'sine qua non' is the *sharing* of a certain emotional moment.

Very often, when it comes to cases with severe dissociation, the Significant Other can constitute a direct threat to the child, complicating the situation even more. The result is that the child in question frequently finds herself in an immediate danger of becoming overwhelmed by strong affects. Strong affects tend to ruin the possibilities of constructive mentalizing. If conditions such as this persist, this leads to a child gradually becoming more and more

alienated, more and more in the process of establishing an identity as the 'Wicked One' or the 'Bad One' with a sense of shame will eventually permeate the Self.

DID versus Everyday Dissociation – a continuum?

Variations in the severity of the processes described above are obviouly feasible. Following Janet, we may conceive of a human tendency to use *dissociation* in the service of the ego – whenever we are under the onslaught of emotional experiences that 'stand out' from the 'ordinary', whether they are accidents or life-changing encounters. A person who has come of age in a safe environment, a stable secure family with 'good enough' parenting, should have developed a secure attachment and – as a consequence of this – a reasonably stable personality. However, as life is known to take unexpected turns, even such an individual may, at times, become overwhelmed, by emotions or by the significance of the moment, thereby activating the tendency or (should I say) the ability to dissociate. The result of this might be called 'Micro-traumas'. They get 'sanded' or 'smoothed' away by everyday life, however they are still residing in your memory, often in the form of 'stills' (frozen images); such stills should be converted into movies when working in a psychotherapy setting so as to be able to insert them into the bigger picture.

Multiple Personality Disorder (today Dissociative Identity Disorder: DID) may be conceived of as a chronic form of PTSD.

The author holds to the concept that this ability (to dissociate) is largely non-existent, especially when it comes to psychosis. The connecting links are missing, or easily broken, resulting in different forms of fragmentation. Characteristic of PTSD is the repeatedly intrusive images, whereby the patient is thrown back in time. The classical 'movie' scene depicts the profusely sweating hero waking up, shouting (making the bewildered heroine deeply upset). In his mind, the 'hero' was back on the battlefield. The present-day situation doesn't exist.

If we find that the patient has obvious gaps in memory, this points towards the possibility of 'fugue' states and DID. Here is a metaphor: *"Imagine that you are walking in deep snow; turning around, you will find your footsteps. If some steps are missing – you may have gaps in your memory. A loss of memory may happen during deep trance states, often making the subject believe that he/she must have fallen asleep."*

I want to underline the difference between, *"the return of the repressed"*, and *"the return of that which is dissociated"*. A *'dissociation'* is thus a state of experiencing, a kind of an *event-happening*, made up by subject and object, where the sequence of experiences through the senses get linked together: this is re-supposing there is an ability to link.

However, in psychosis, there is no linking (see also Bruckner, 2013). The reason for this might be found in the *'soma'*, like an inability to establish what constitutes a figure on a ground (Palmquist, 1996); or an inability to group or to label experiences; or an inability to bear strong affects (Zetzel, 1970), etc.; or to be a psychological averting of this. Linking results into a train of thoughts, accompanied by affects – are how emotions are formed and then, in some cases, they may become unbearable. This is actually food for another paper – but it is interesting to note here that some individuals come down with a Reactive Psychosis, and others with PSTD (you may also find mixtures of these). In the next paragraph, I wish

to present a few thoughts on the diagnostic problems that may arise in connection with dissociative disorders – in my experience.

Psychiatry and the Problem of Diagnosing Dissociation

None of the patients presented in the case vignettes in this paper were diagnosed by 'Psychiatry' as suffering from dissociative symptoms. One explanation to this is probably the fact that the point in time when they were admitted to hospital lies between 50 and 40 years ago. The generation of psychiatric workers of that time are since long retired. As I recall, the knowledge of these states was virtually non-existent in 'psychiatry' then. However, when supervising at all levels in a lot of modern psychiatric organisations, I have met – much to my disappointment – the same lack of knowledge and what is quite often sorry to say a low interest. Diagnoses are often based on visible symptoms – not on careful scrutiny, penetrating interviews, or reflective work.

One patient (aged 17, at our first encounter) had previously been admitted to Child Psychiatry, then to Youth Psychiatry, and finally to Mental Hospital Care, often in "heavy" units. None of these institutions discovered the dissociative traits, nor did I at that time (I had only recently graduated). Instead, a motley of diagnoses were used, such as: 'Persona Immatura', 'Persona Pathologica', 'Schizophrenia' (!), Manic Depressive Illness, Mutism, Hysteria, etc. When the concept of 'Borderline' entered the scene in the late 1970s, patients of this kind with obvious 'identity issues' were all labelled with Borderline Personality Disorder (BPD). Nakatani (2000) provides a review of the literature beginning with Janet. It was not until 1980 that *dissociation* was adopted as a diagnostic category in the DSM-III. The accumulating evidence of what came to be known as PTSD, in particular after the Vietnam war, led to a kind of revival (since the days of Janet) of these phenomena, as well as to what were the causes for them.

Another reason for this difficulty may be attributed to the very phenomenon in itself: After all, it has been developed out of a necessity to "shelter" – to hide – thereby protecting the psyche, the 'Soul'. The patient is not "flaunting" her symptoms. Personally, I was only able to pinpoint the phenomenon by carefully putting together, over a rather long period of time, observations that eventually formed into a pattern. Consequently, one prerequisite is an interested and open-minded observer who, over a period of time, may puzzle together pieces of information that finally evolve together. On many occasions, there seems to be a lack of time – due to the stress, the accentuation of a fast enough through-put of patients. And, probably still a lack of knowledge, sometimes even calling into question the phenomenon in itself.

While at it, I continue to underline that as far as I can see, variants of dissociation often may be elicited in everyday life: car accidents, assaults and other frightening experiences as well as other incidents that give rise to a strong emotional response. Reactions like these are often neglected by the person, who is the unfortunate victim, as well as by many a medical staff. One way of counteracting this might be using scales such as 'The Impact of Event Scale', originally pioneered by Horowitz, Wilner & Alvarez, 1979. I have found that introducing such an approach may help patients to understand their own reactions to their appalling events.

Dissociation and Dissociative Identity Disorder (DID)

The psychoanalyst, Rickard Kluft (1990), looks upon dissociation as: *"a separate state of Self,*

having a relatively stable and lasting pattern of selective mobilization of mental content, which can express itself in behaviour, adopt roles and play roles based on a sensitivity for outer and inner stimuli".

This 'Self-state' displays a rather stable neuropsychological pattern, acting as receiver, performer, storing perceptions, as a way of processing them. It has its own sense of identity and it has a capacity for the initiation of thought and action. The creative 'carving out' of new personalities is just a secondary phenomenon – many personalities are not that elaborated, meaning that you should not use the word 'personality', but rather *alter* (Latin: other selves). These *'alters'* appear in a complex pattern of dissociative, affective, somatoform and post-traumatic symptoms.

Disorders of thought seem to be quite rare – if the person in question has experiences of speech "inside" – often a trifle metaphorical. One patient said that it was – *"as if someone guided my steps"*. These 'Other' selves might behave differently: they might – display another cognitive style; another way of speaking; other abilities; changed laterality; or other memories. "Alters", presenting as age-regressed children, seem to be more common. Peculiar corporal differences may be at hand; cases have been reported where the main self-displayed have better sight – one *alter* had worse sight, their left-eye turning outwards. Differences in: blood-pressure; pulse; allergy sensitivity; parameters of the autonomic nervous system; threshold for pain; have been reported.

These other selves may embody periods of the patient's life: as traumatised victim or perpetrator. The *"Host Self"* – (the *Inner Psychic Helper*, *ISH*, a term used by Ralph B. Allison (1980) is the one having the executive control, most of the time, often carrying the person's legal name. This *Host Self* usually appears to be very depressed, overwhelmed, forgetful, restrained, occupied by somatic complaints, but is capable of giving warmth – contrary to any individual, characterized by *Borderline Personality Disorder* (*BPB*).

What Motivates the Appearance of a New 'Alter'? – In the author's opinion

In my opinion, the appearance of a new alter can be due to three factors:

1. An inner pressure emanating from strong affects or impulses. Basically, we have an over-pressurised system searching for an outlet. The developmental age of the individual determines their reactions, which are often efforts at projective communication. From a neuropsychological perspective, this means that the patient communicates using their body-language, subconsciously, in an attempt to share their – often gruesome – experiences: i.e. *"See what it feels like to be me!"*

Two Vignettes Demonstrating Age In-congruent Behaviours

Case Vignette 4

> *Towards the end of the session, I notice a rising concern – what will happen when I tell that this is it; that this is all that there is for today? I am fearing some unspecific reaction; as if the patient was a little child who has been abandoned. Eventually, I say, probably in an all-too-nice voice, "Well that's all for today". This results in her suddenly becoming completely mute, sitting immobile, "Lost to the world". This might be the "mute unreachable alter". This patient often 'switched' between this and the "mayhem personality"*

alter, where she jumped out of her armchair and started to tear down the office.

Krystal (1988) would speak of both affective and cognitive regressions.

Case Vignette 5

Another example, the same patient, after about two years in therapy, regularly 'switched' between these alters. She just could not tolerate any separation; became completely unreachable on many occasions; or reacted in a way that forced the therapist (me) to physically hold her [3]*, for a while; otherwise she would tear down my office, not aggressively at all – but with "tender force" – as if she was a little girl panicking. This made her calmer; she could then be talked to like a small child – "You'll see! Things will get better". She was very much like the little child in a temper-tantrum, who alternately must be held (tenderly), and then released. Eventually, the patient understood (or rather learned) that I was going to return, not only for the next session, but also after longer breaks.*

If we look upon this from the perspective of attachment theory, her outbursts become understandable: her attachment was very insecure and she was also very afraid of her love-objects, so there was present a huge portion of disorganisation. Some years later, she told me that she feared that every time that she approached my office that a completely unfamiliar person would open the door, looking very surprised, and telling her, "*Anders Palmquist – who? Is he supposed to work here*"? As expressed in an older vocabulary, she was lacking "object constancy". What took place between us at our very first meeting, seems to have made a great impression on the patient – planting a seed of attachment.

In order to manage the outbursts and often violent behaviour of this patient during the first phase of the treatment, besides from struggling to contain her, I had to think a lot of what were the effects of our 'fights' on the processes itself. Apart from Eissler (1953), I found nothing of help in the psychoanalytic literature. Eissler writes: "*Clinical reality, of course, is so highly varied and provides so many unforeseen situations that it is impossible to set up a standard technique which would meet all exigencies of practice*". Thus, he introduced the concept of 'Parameter of the Technique', describing it "*as the deviation, both quantitative and qualitative, from the basic model technique, that is to say, from a technique which requires interpretation as the exclusive tool*". He recommended a rigorous use of such an intervention – such as: "(1) *A parameter must be introduced only when it is proved that the basic model technique does not suffice*; (2) *the parameter must never transgress the unavoidable minimum*; (3) *a parameter is to be used only when it finally leads to its self-elimination*". Needless to say, this means that the said intervention should be abandoned when it has fulfilled its purpose.

Back to the Causes of Alters

2 Back in 2003 (Palmquist,. 2003), I wrote that we should look upon the therapist's state of mind as a kind of an atmosphere in which the barometer is made up of the therapist's expression and their body language. Today, I am fully convinced that the patient – more or less subconsciously – scans the entirety of therapist, hunting for signs of rejection, disgust, insecurity, unease, etc. Depending on their findings, the patient acts accordingly. Even an apparently microscopic resemblance to anything connected to their abuse can make a huge difference. Often, the therapist can be quite unaware of his/her "radiation", thus providing the seeds for apparently baffling actions of the patient. Once, during a session, my

stomach made a sound, the patient looked somewhat bewildered so I explained, *"I'm probably hungry"* – which made her utterly frightened and put her, quite paradoxically, into a seductive alter. At the time, I did not understand her behaviour – I just thought that she behaved mysteriously, all of a sudden, provocatively.

Joyce McDougall (1996) has written about eroticization as a defence in very early trauma – but the patient's presentation of an 'alter' was a way of coping rather than an eroticization *per se*. It was an effort at synchronizing with my probably ravenous look: instead it was just Me, just being hungry. This seems quite obvious now, but certainly not at the time. This took place more than 40 years ago, years before my own personal analysis.

3 The patient is very alert, scanning the outer world, using all their senses. Anything, a smell, a sound, an impression, or even a colour, can turn into a signal (please observe – not a symbol (Wright, 1991) of something threatening). This is the classic form of *traumatic perception*. I remember reading a newspaper telling of a little girl, a refugee from Bosnia, who became lost during a New Year's Eve celebration. After several hours of searching, she was found hiding under a tree. She said that, when the fireworks started to explode, she was back in Bosnia, knowing that she should go and seek shelter immediately. What happened was an instant transition into a specific affect, or ego state, triggered by a contemporary signal. A patient told me once how the voice of her grandfather used to change, suddenly ... *"sex coloured his voice"*.

So, again, we find a constant scanning, motivated by the necessity to avoid any potential repetition of the trauma. Another patient told me that every time she noticed a white curtain wave a little, she got flashbacks to being back in the room where she had been abused, which had had white curtains.

Case Vignette 6

The patient, who was 30 years of age at the time told me the following story: "I was at the folk dancing club. I did not feel well, but decided that I should dance. A man whom I had only met some times before invited me to dance with him. We danced really well together: I enjoyed us dancing! But, then I heard people say, "Is she ill in some way?" and then I started to feel as if I am not dancing by my own will; it was as if someone else was guiding my steps. I moved slower and slower as if my legs and arms – Yes, my whole body – sort of comes to a standstill; my body has a life of its own, as if I am not dancing any more. The music seems to be far away and I feel that someone is carrying me away, putting me on a landing. I can hear people talking, as if their voices are distorted in some way. Their voices tell me that I am sick, under the influence of drugs. They could have done anything, everything, that they wanted to do to me".

An Attempt at Interpretation (written in 2003)

At this time, the patient's therapy was well under way and a couple of years had gone by, the transference was often sexually charged, I was sometimes almost tormented by sexual fantasies, that were quite disturbing to me, not to mention to my supervisor – indicating that we were closing in on the trauma. Please notice that the patient had ended her story by saying, *"They had done everything they wanted to do to me"*. Is this a wish? A fear? Or what? Her dance partner can be discerned from the prevalent eroticization and a spontaneous

trance-state surfaces, the mute 'alter' appears. We find many signs of a clinical trance state – but there was no hypnotist!

Could it be that the dance set into motion various impulses, affects that she was not able to contain – indicating a situation in which she was carried away by; she did not have the feelings, they had *her*; feeling that something terrible was going to happen, again – resulting in an alternative state of consciousness – as a defence.

The transference was filled with representations of her parents, the perpetrator – causing pain, despair, arousal, longings for the ideal parent; both libidinous and affective components also reflecting a grown-up being around, but who did not salvage her. Having done some serious self-reflection (see also Young, 2020), I managed to understand a significant aspect of my "counter transference"; it was not so much the actual fantasies, as the overwhelming intensity of them, that was tormenting me. Too much!

Reflecting on a poor little girl being subjected to situations that were simply too much for her "system", besides (if that ever could be overlooked) the actual sexual assault in itself, again, we can see that the theory of affects pioneered by Silvan Tomkins (1991) shows its value. The intensity can cause over-stimulation, and it can also contribute to the patient's hard-to-endure sense of being part of the trauma; at the same time, it can cause anxiety, the 'affect storm' by itself can cause too high a level of arousal, maintaining the intensity, thus generating intense discomfort – as Tomkins suggests. The patient also felt extremely shameful, becoming almost delusional, regarding her wickedness, as she believed that she was the one who caused all this! Her relation to the primary caregiver was extremely ambivalent. Very often, the patient was severely beaten up; already, during her first years, there seems to have been a failing attunement and lack of synchronization.

Technical Comments – How to deal with alters or more common dissociations

In 2003, I wrote that David Spiegel (see Kluft, 1990) mentions the well-known fact that if a therapist, already at the 'start' or during a treatment, attempts to pinpoint the actual trauma, this might make the patient re-live the trauma again; on the other hand, ignoring the trauma might fuel the pervasive feeling of her being abandoned. In my view, this is an often overlooked problem – I have met many a patient who has been re-traumatized by well-intending therapists (well, certainly most of them). But, before I discuss this dilemma – let me present some of Kluft's thoughts!

He recommends that the different alters should be requested to consult each other. His most common intervention is *"Now listen, everybody!"*. He advocates caution, feeling that only alters that are compatible (i.e. not representing any threat), should be brought into contact – until a greater ability to contain, and integrate them, has been attained. This takes a while, getting used to telling the patient: *"I want all the Sara's to feel at home in this room"*.

The difference between making a splitting patient aware of the different "white" or "black" aspects of something, someone – is often the *permeability*, the ability to move between the separate ego/self-states, which varies from an almost instant contact with it, or understanding it, to absolute permeability. The orthodox therapist, unfamiliar with such alternative states of consciousness, often goes wrong right there.

When a borderline patient is confronted, in these respects, she or he often gets infuriated, or anxious, but can – after a more or less trou-

blesome working through – see the validity in what the therapist says – but the dissociative patient can often be overwhelmed by anxiety and so escapes into another 'ego state' – or simply does not understand at all (⇒ might not even "be present"). Work with dissociative patients offers rich opportunities for becoming bewildered, providing a sense of something completely unreal. Does the patient manipulate me? Am I cheated upon? Am I sane? And it is exactly these very feelings that provide the essence of it all – someone is wanted or needed to help me (the client) to clarify my current reality!

Part 2: On the Practice of Hypnosis

Teaching the patient some hypnotic techniques can sometimes help the patient to control some of their disturbing memories and dissociative states, to deal with sorrow, despair and rage – but you must, at all times, very carefully estimate the patient's capacity to "be in charge". As the dissociation helped the patient to survive, it is intimately connected to the abuse – thus patients often have an ambivalent relationship to hypnosis.

Trance states can be disorganizing, but Kluft holds to the idea that the biggest danger resides in the therapist's lack of understanding their power and of all the subtle nuances in the transference. When it comes to dissociative states of a 'not entirely subconscious' kind, that is when we find a certain permeability of the barrier between these separate states, it is therefore recommended that one creates a psychological map, in order to provide a structure, in close collaboration with the patient. Visit every "place" for as long as it takes, trying to reconstruct what happened – in essence, creating a history of each dissociative state. After all, these were created in order to help the patient deal with overwhelming situations, or aspects of them.

When the patient enters such a state, it is necessary that any questions asked must be put forward in an "exploratory" way – such as, *"What is happening now? If you look around, what can you see? Can you describe anything in closer detail?"* It is far too easy to direct the patient, or to influence them, or even to coerce people. Often, the essence of such a situation is the fact that the patient was seduced into this or that, or forced, or coerced! By the way, hypnotists sometimes are accused of creating false memories in patients – so, not minding about the way that you speak could be the cause of such.

Putting questions, in such a way, resembles Guided Affective Imagery (Leuner, H., 1984) – even though what is revealed was anything but symbolic! One should therefore carefully monitor this process: the trick is always *to follow the patient* – with the uttermost respect for the patient's hesitation. Take it easy – the patient is in an *altered state of consciousness* (*ASC*), requiring the therapist to have a very delicate – almost tender – attitude.

In my experience, it is very common for a patient to talk about a particular situation, many times, sometimes years apart, each time providing more details. You will certainly remember what the patient told, but the patient may be quite unaware of having told you!

A Short Vignette (7) – Illustrating a patient's lack of memory

> *The patient told her therapist that, when she was 11–12 years old, she had met a man who wanted her to go to his place. So, they drive by her parents' home, where the patient told*

her parents that she has met a man – but, getting no response from them (!), she returns to the man. They drive to his place. Having arrived, he wants her to undress, so she does – telling her ('by-now-baffled') therapist, still occupied by the lack of response from her parents – said that: "I did not understand what he wanted." The therapist stared at her incredulously: *"But you have told me that, long before this, your brother wanted to have sex with you, when you were 8-9, your grandfather had already begun – you must have known"!* Patient: *"Experiencing things such as this, I don't remember anything else."*

Obviously, the patient had entered into a certain type of ASC, which had been created by her for the sake of protection! Thus, it is very important to make the patient aware of these states – and – to help her establish a sense of continuity; helping the patient access their more distant history, as well as the present one. In this vignette, we can find a classical symptom of dissociation: the *absorption*.

I want to stress the fact that these ASC are states that are actually protecting the patient – because often, as a therapist, you may feel counteracted. This is "someone" who is trying to protect themselves, sometimes in very destructive ways. It is necessary to teach the patient to note any "early signs". Furthermore, it is important the patient tells their story in great detail. Not asking about these details, might be interpreted as having a zero-interest. The therapist should also be extremely alert concerning his/her own feelings.

"What do I experience?" (Tansey & Burke, 1989). Patients often tell their outrageous stories in a neutral, monotonous way, as if reading out aloud from a rental contract – as a therapist, you must notice this and react! It is all too easy to be seduced into a "pseudo therapeutic" stance. The patient says, "*Then Daddy hit Mommy; so, she took a knife and approached him.*" Therapist: *"Ahem... what do you think of that?"*. Much better could be: *"Oh dear – such a horrific experience! You were only 9!"*

"Nota bene!" "Please note well!" – if our therapist happens to feel that way. It is not uncommon that the therapist realizes – only afterwards – that the patient has talked about something hideous, yet showing no emotions at all. First of all, the patient needs a definite confirmation of his/her experience – only then, it is possible to collect all these situations to the mutual history of patient and therapist – often the therapist may retell the story much later: this time, including the client's emotions – making a good 'working-through' possible: even better, if the strategies of the patient can be demonstrated in the interplay.

A decisive question for the patient is whether the therapist is genuinely interested or not, cares (or not), and whether the trauma is going to be repeated. This may sound self-evident – however the therapist might become exposed to many shrewd attempts from the patient, who often (more or less consciously) wants to insure him/her self of the therapist's good intentions. Not only good enough, but good as in 'extremely good', above all possible suspicions, the "Ideal Significant Other".

Short Vignette (8) – Describing possible pitfalls

Once, in the beginning of my clinical career, I made a huge mistake. Of course, I have made many more ever since. After some years in therapy, a very abused girl had really taken me to her heart. At the time, neither I – nor anyone else – was aware of the abuse.

The concept of attachment had not yet reached everyday clinical psychology. Much later, she told me that – after our sessions, she would go home, pull out a baby's feeding bottle, warm the milk, then get into her bed sucking the

bottle, like an infant. Anyhow – I was wondering, *"How come?"* – as everyone else disliked her – *"How come that I did not?"* I even seemed to like her, hence I must be a very special person. I just could not bear this idealization – so I said, *"Oh, I am only a common human being"*. I will never forget her panic stricken, *"NO"*, she was full of pain and fright! The bottom line was that – if I was not an exception – well then, she was in great danger! Somewhat later, we seemed to have reached an impasse, attempting to find a way out, so I came up with the idea that I had to demonstrate to her how her past was interfering with the present.

She had told me that once her mother had simply taken away her favourite doll, which was very precious to her. Then, her mother had beaten her, as she began to cry. Every session, she brought along a pillow, blue, with the inscription *"I love you"*. She was always clinging to it. I said to her, *"Maybe, we could perform an experiment here: You are going to hold on to your pillow, I will get up and try to take it away from you – Would that be okay?"* She said, *"Yes"*, so I rose, put myself in front of her, and reached out for the pillow. What happened? Much to my surprise, she clung to the pillow, staring at me in such a way that I realized she was not looking at *me*, instead someone else, her mother? She had entered an *ASC* – just like that! She was re-living a traumatic incident. This is an example of the *Traumatic Perception*. As a result of this phenomenon my identity got mixed up with the perpetrator's.

According to Ignacio Matte Blanco (1980), *"In the night-time, all cats are grey"*. In plain English: Having become traumatized the individual thenceforth is constantly scanning the environment for signs that might indicate yet another trauma/perpetrator. If almost anything within the therapist's body language, or the situation, to the least possible detail, reminds the victim of the trauma, then it might turn out that the therapist suddenly is mistaken for the perpetrator. Often our therapist does not understand what suddenly took place; thereby also becomes bewildered, which in it's turn does not help the patient. So then we have a bewildered therapist and a horrified patient... The fright of the victim has the power to more or less momentarily alter (sic!) the perception.

Normally, this does not happen with the average neurotic – but be prepared!

Case Vignette 9

This patient had a most troublesome upbringing, being beaten from early on, abused, and she even had a short sojourn as a prostitute, in her later teens. She had had some contact with psychiatry around 20 years of age. 4 years into therapy, there was a re-lapse into 'binge-eating'. At the same time, and in an interplay with this, she was engaged in some excessive surfing on the net, on chat sites where the exchange with many males infallibly resulted in sexually charged conversations. She described to me how she felt she was being taken back in time and she was getting increasingly anxious. As she was telling me this, she often closed her eyes, and – as far as I could judge – entered into a spontaneous trance-state, thereby reliving various traumatic situations that were sexually charged, as well as re-living memories of being beaten. Her father used to order her to pull down her knickers, and then bend over his knees, whereupon she was beaten with a belt – This went on into her teens.

The therapist adopted, quite automatically (today, I would say synchronizes) to this form of speaking to her, as you would speak to a person in trance: that is – as simple and as explicitly as possible – rather slowly, mostly using concrete (not abstract) concepts. You might compare this with how to relate to a child who is playing, a kind of a concrete affective imagery. Each new story provided more details – she had told me before, but

then in very schematic ways: like gradually enlarging a map. At the same time, a new element had popped up: she wondered, "How did I bring myself to you today – I know that I entered the bus, but then ... nothing?" Once, she was found sitting on a bench in another city, by a nice policeman, who talked kindly to her, then helped her to an emergency department reception nearby – from where I got a call. In the receiver, I heard the voice of a small child, apologizing – unaware of what had happened.

After a rather long conversation, the patient "regained herself"; her voice got older and she said, "I will try to show up next time". So, she does. I try to comfort her, as in comforting a small child, assuring her that everything will turn out just fine, adding that, "I guess it is difficult for her feeling that lost, not being altogether safe with me".

Gradually, these spontaneous fugue/trance states gradually ebb away, she recovered control over her ability to enter into trance states, without losing the return ticket to the present. At the same time, her stories became more detailed, the affects more adequate and proportionate.

Two Main Directions

When dealing with traumatized persons, it might be a good idea to conceive of two main directions – firstly, **(1)** the development of relationships; and then, **(2)** the specific working through of the trauma. Of course, in reality, there is no real division. Each trauma affects the individual in a way that is very much determined by the victim's age, basic personality and relational patterns, but – for the sake of making the variables more distinct – this division could be defended.

The Development of Relationships

This was the heading that I used 17 years ago – which were due to the tools available at the time? I cannot say that I found valuable tools in the traditional psychoanalytic theory. What I and my team observed in clinical practice, made sense, although we – sorry to say – did not delve deeper. We found that, once a therapy had begun, something seemed to happen with the patients.

Seemingly, there was a correlation between time passing by and the capacity of the patient to, "*stay reasonably calm*" until the next session. Firstly, there were a few meetings, with same level of anxiety; then, over a period of days, then lasting a week and so on. In the first year, the summer vacation mostly passed by easily, but – in the second year – during the summer, the separation did cause some deeper anxiety. Psycho-analytical theory tells us that the patients got angry, and – as a result of that experience – the drive induced anxiety. I would like to state here that generations of therapists have had huge difficulties tormenting their patients with questions and interpretations concerning this alleged anger. Gradually, a more relational approach began to focus with 'Object Relations', particularly the work of the so-called 'Independent British School'. But it was John Bowlby's postulation of the attachment drive that finally filled the tool-box with usable tools. I will go deeper into that point, but – first – a more general approach.

The prerequisite for a "psychological working-through" is that the patient establishes a deeper relation with the therapist. Some patients possess a faith in that others can be facilitating; are emphatic; entertain compassion; in short – they are "normal neurotics". If not, *idealization* may be used as a defence; this may be both pathological and normal – the patient's life can constitute an over-abun-

dant planting 'soil' for various pathologies, thus making idealization of the therapist necessary. An expression of a wish that the therapist's personality differs – in a favourable way – from those who made life insufferable. Inevitably, the therapist must enter into the process as a genuine human being, equipped with special knowledge of attachment theory, Altered States of Consciousness, and – nonetheless a "good enough" form of self-knowledge: – γνῶθι σεαυτόν – [*Gnothi Seauton!*] *"Know Thyself!"*

A comment about "Knowing Oneself"

I have written that a "good enough" level of self-knowledge is mandatory. Easy to say, but how to attain? First of all, a "good enough" 'own therapy' should constitute a pre-requisite for every therapist. By "good enough", I mean a therapy that has resulted in the person developing a freedom of thought and speech – an ability to stroll around in one's mind and not be tripping over hidden corpses. Access to your innermost feelings is to be recommended; if not being mandatory. It should be of such a length that a secure attachment (with the therapist) has been attained.

George Bernard Shaw once said, *"If you can´t get rid of your family skeleton, you may as well make it dance"* – probably meaning that you should become familiar with your life's work: What are your weak sides; ... your typical sides; ... your positive sides. Besides own therapy, you should make a habit of rethinking every session, maybe making notes (to yourself only), subtle impressions etc. Recently, Young (2020) outlined different ways about how to organize this work. Tansey & Burke (1989) also devised a structured approach.

Of course, no therapist is ever "born and raised", nor has had a "good enough" own therapy, which does not meet up with "difficult-to-contain" feelings, nor fantasies that are suddenly surfacing. The professional way forward here is ... not to be free of such outbursts, but – instead of working with them, and understanding them as "human productions", instead we deduce them; diagnose them; and then, use them in the therapeutic relationship. By no means, is this a piece of cake, particularly as traumatized individuals often display extreme anxiety bordering on the psychotic; have a disintegrating structure; and their defence might be a form of sexualization, especially when it comes to cases of abuse. This is not an example of a "perverted" complexion.

In my opinion, it can be quite testing: especially when the patient tells of a sexually masochistic excess, enters into an ASC in the next session, avoids looking into the eyes of the therapist, or stares intensively, partly out of a fear that the trauma will repeat itself, partly out of a wish about seducing the therapist to repeat it, in order to control, to be in charge, at the same time test *if* the therapist is tarred with the same brush as the perpetrator. Now, for the ability to navigate rightly, both in the material world and in your mind. Watch out for your steps! Someone may want to trip you up!

The Process from the Patient's View

The patient experiences that his/her identity changes quickly, randomly, like pictures in a music video. The significant 'Other' (i.e. the perpetrator) has often, likewise, undergone various transformations, from being a nice, smiling, safe and kind (nearly always) older person, into an unreachable, threatening, tense, face-distorted (i.e. aroused) and alien person. It is therefore mandatory that the therapist can recognize that the patient has witnessed these transformations *"in vivo"*.

It can be extremely frightening for the patient to suddenly experience that the therapist is "radiating" a new frame of mind – and – the therapist, at the same time, becomes momentarily inconceivable and bewildering, especially when the patient suddenly looks frightened! As a therapist, you will have to know what your default emotional state is. The perpetrator may have presented himself as anything ... from cunning, or completely devoid of empathy, to an – at-the-beginning – quite an alluring individual; someone who had something 'special' to offer the patient.

The patient has a huge need – constantly – to reassure her/himself (Crafoord, 2001) as to whether the therapist is free from any tendencies towards exploitation and/or abuse. More deeply disturbed patients tend to display a strong tendency to a love that is impregnated with idealization. This is not always that easy to receive.

The therapist's defence can often express itself in a drive to interpret, but – and this is crucial – it is imperative that the therapist also allows themselves to be 'loved', whilst at the same time recognizing the desperate wish of the client to attach themselves to someone (the therapist) who is ... hopefully good; who postpones interpretations until they can be taken in; who does not become warded off, and who makes the patient able to understand her/his dilemma. One severely abused woman finally asked me, *"Can I love you?"* Here, it is absolutely essential to understand that this 'love' is mostly that of a (small) child. Of course, there are sexual ingredients – but, in supervision, I have seen that this "original love" is often interpreted as a defence, resulting in a rejection of the patient's basic need to attach, not to say that this is quite terrifying for the therapist. Too many times, a patient has been forced to abandon her/his inner world, his/her identity, in favour of the perpetrator's. As one patient said: *"Granddaddy never came to me; I was the one who came to him"*. This dynamic can disguise itself in many ways. As a therapist, you should never psychologize, especially when this is not needed (which is often a form of defence); the patient will notice immediately the therapist's uncertainty, that sort of uncertainty being very familiar to the patient.

Working Through the Trauma

Every trauma is as unique as the individual who has been subjected to it. There is a huge difference between: (a) treating an engineer, who happened to drive a train that had mangled a person, who had committed suicide by standing on the tracks; as opposed to (b) the "average neurotic" male, ordered to kill enemies at war; – and (c) a woman, who throughout childhood into her teens (sometimes far longer), has been systematically abused by adults for sexual purposes, often in a more or less depraved way.

The obvious and huge difference lies in the question of pre-morbidity; the first two patients had, prior to the traumatic situation, presented with a more-or-less well-functioning personality; had a capacity for "inter-systemic" conflicts, meaning an inner world populated by mostly good objects; had ego functions permitting the working-through of normal conflicts; had a capacity to bear strong feelings; had a well-functioning "emotional library" and a coherent, mostly good, image of Self. The abused victim, on the other hand, may well have lacked all this!

A very important capacity is being able to stay put in the moment, even under the onslaught of strong affects: think of a person, not regressing during a severe separation. Put under the same sort of stress, the victim of abuse may – regress; enter into a fugue state; display traumatic perception; experience de-personalization; and where the patient, at the end of the session, does not return to "today"; re-

mains in an intense state of anxiety; with their *observing ego* paralysed. Sometimes, I have successfully helped such a patient to come back into the 'here-and-now' by requesting the patient to, *"Please look at me … when you look at me, you are safe again"*. Obviously, this presupposes that the therapist *is* well anchored in the here-and-now, and in her or himself, which is also made possible, if a good enough level of attachment has been attained.

Our hopefully average neurotic engineer – contrary to the above – may often be prompted to tell what happened and react with a dissipating cry, or anger, etc. and put what happened into a wider perspective, go home, and soon sleep well again, comforting himself in spite of some flashbacks, retaining his good sense of Self. On the inner scene, knowing that *"I am a good person; I did not kill that person by will; it was totally beyond my control"*.

An railway engineer, whom I met at the psychiatric emergency department, years ago, did not present with particularly strong reactions: the train he was driving had hit a car parked on the tracks by the driver, who was still sitting inside. He was traumatised. He readily consented to a short hypnotic seance. His emotional reaction was some frustration, close to, and after the impact. He was fully relaxed after the hypnotic session, and was very surprised at having a second-by-second memory of the time, prior to the impact. By the way, this is an example of the everyday dissociation; when staring at the car he entered an ASC, a certain 'state'. When reviving that state, whilst in a hypnotic trance, he made contact with his second-by-second experiences. He was sent home, being told that he could call back if needed, but he never did.

In contrast to the engineer mentioned above, a woman – as described in the concluding vignette – lacked the capacity to tell her story right away. In my firm view, it is absolutely wrong to be pressing for details right away, with or without the use of hypnosis. I remember the little tense, rigid girl from Sarajevo, whose home was shelled causing the death of her parents, in front of her, as well as her playmate. She was interviewed, answering matter-of-factly, completely devoid of any emotions, similarly to the interviews of survivors of the 'Estonia' only a day after the accident (when more than 850 people died). Persons, who are in apathetic shock-states (which could also be described as spontaneously arising trance states) or a psychological refractory state, should not be asked to account for their most horrible experiences. Being subjected to such, only reinforces the defence mechanisms: the petrifying; the freezing.

Something Utterly Crucial in the Treatment

If life-shattering occurrences are ever to be integrated into more harmonious ways in the usual fabric of life, the pain of the trauma must be given time to run its course; trust in the therapist must be attained and the therapist should possess a definite *"sense of good enough pitch"*. Also, it is fundamental to try to reach an understanding that abuse, whether it be sexual or else, has profound relational dimensions. Could it be that all traumas have this dimension, whether caused by accidents, tsunamis, or by abuse? On the inner scene, the psychological essence is that the "name of the mother" fails, if I dare to paraphrase Lacan (2013): *"The One, who should protect, does not, or is not even at hand"*.

God – probably a woman in the Sumerian myths – died in the concentration camps. You cannot speak of the extreme horrors to anybody. Thus, the therapist must become somebody, then somebody special, then my therapist. Anyone, who has ever met a little child rushing towards their parent, exclaim-

ing, *"**My** Daddy"* understands the power of this (also, read Aleksijevitj, 2004 describing childrens' reactions to their parents' death when getting lost). It is mandatory that the patient encounters a genuine human being, capable of providing emphatic feedback. Many treatment programs have failed in these respects, even worsening the symptoms.

As abused patients very often present with an attachment impregnated with insecurity and dis-organization, as a therapist, you must allow enough time for the attachment process. If you do not trust your therapist, that is you have not built up an attachment that is secure enough, then you are in danger. Diving into water, not knowing neither depth, nor for how long, requires some safety precautions: sometimes, I have told a patient, *"You don't know if I have a diver's certificate – but I do!"* (True).

Contributing to this is very often a pervasive sense of *guilt*, or *shame*. This can be bewildering to the therapist, conceiving the patient as a victim (which is true), whereas the patient looks upon her/himself as the one who is the villain, the root of it all. *Shame* colours the patient's life, making life extremely hard to endure. *Guilt* emanates from a wrong doing. *Shame* becomes an identity; you *now become* defective (Nathanson, 1992). One patient was convinced that she had something inside, so ugly, so dangerous, that she literally had to starve it to death, which became bordering on a Delusional Syndrome. She was convinced that she *"did not belong to the humans"*. The movie, *'Alien'* resonated well with her. This means that patients have to accept living miserable lives; that all kinds of misery may fall upon them; on top of that, victims of early abuse often have to fight a powerful repetition compulsion. This results in a situation, often to the horror of the therapist, whereby the patient seems to place her/himself in awkward dangerous situations. On the inner scene, this is a way of dealing with the trauma.

So, the patient must attain an "object" – constancy vis-a-vis the therapist – a secure base. Another extremely significant variable is the utter loneliness of severely traumatized persons. The next paragraph will deal more with this, as the Mirror Neurone System has much to offer, explaining why.

The Mirror Neuron System – Embodied Simulation

There is a growing body of research relating to the neural basis of our social behaviour. As this paper focusses on everyday clinical work with patients who use dissociation, I will limit myself to provide only a few references for the reader who wants to become more familiar with this type of research. Apart from the ones cited below, I will provide some additional references at the end of the reference list.

In the 1990s, a group at the university of Parma found neurons that seemed to be significant in the perception and execution of motor actions (Gallese *et al.*, 1996; Rizollati & Craighero, 2004). They named this type of neuron, a 'Mirror Neuron'. A definition of a mirror neuron seems to be:

> *"a neuron that is somehow modulated in response to some kind of action observation and some kind of action execution. The main proposed function of mirror neurons was also based on the symmetrical idea of self-other mirroring, namely some kind of understanding and recognition of the action and goal of the other based on matching the observed action with one's own motor repertoire"* (Brinker, 2010).

The concept of Mirror Neurons has been the subject for divergent opinions. Brinker (2010) proposes a wider definition stating that: *"given a cognitive system with sensorimotor experience and teleological motivations, 'affordance' are the action invitations that are presently de-*

tected in the environment. An affordance alerts to a potential goal and a possible action that the organism could engage in the present environment". She suggests that the findings, *"might point to the need for an even more radical reinterpretation of the motor system than those suggested by the Parma scientists".*

Pally (2010) also focusses on the concept of *'shared circuits'.* She writes (p. 381) that: *Shared circuits operate by re-creating the Other's experience in the same brain region used for Self-experience.* She provides an in-depth discussion of the mechanisms involved in Social Neuroscience.

Grèze & Dezecache (2013) conducting research relating to Neuro-Psychological responses to threat signals conclude that: *"Social signals that include emotional displays (signals related to threat) can be considered as prompting a wide range of opportunities for actions in the observer, even if these opportunities do not materialise into overt actions".* However: *"one need to decipher the emitted emotional signal and predict its immediate future, while preparing to respond in an adaptive way".* Consequently, they favour the idea that we what we have here are two processes; the first one governed by 'shared motor representations' and the second one by 'emotion to emotion' mechanisms.

Bastiaansen, Thioux & Keysers (2009) state that, *"Humans have an astonishing capacity to intuitively grasp the mental states of other individuals".* They cite Brass *et al.* (2009), who suggests:

> *"that it is the 'control' of shared representations by the tempo-parietal junction and parietal prefrontal regions (e.g. by virtue of assigning agency and suppressing externally triggered response tendencies) and not the shared representations per se that pave the way to understanding others".*

Gallese (2006, 2009) entitles this *embodied simulation* because the same neural state is realized in two different bodies, and the other therefore becomes 'another self'. The latter paper deals with the problem of the *"mysterious leap from the body to the mind"* (in the words of a colleague) putting forward the "neural exploitation hypothesis". The mechanisms *"originally evolved for sensory-motor integration were later on accepted as new neuro-functional architecture for thought and language, while retaining their original functions as well".*

Vittorio Gallese is a clever and productive researcher/writer in this field. In a paper (Gallese (2006), he presents as a preface a quote from Freud (1921): *"A path leads from identification by way of imitation to empathy, that is, to the comprehension of the mechanism by means of which we are enabled to take up any attitude all towards another mental life"* (what is better is: 'inner spiritual life'). He takes, as a point of departure, a paper by David Olds who discusses the relevance of some recent neuroscientific discoveries, emphasizing the role of Mirror Neurons in the building up of a person's identity. Gallese writes:

> *"To perceive an action is equivalent to internally simulating it".* Later on: *"When I see the facial expression of someone else, and this perception leads me to experience that expression as a particular affective state, I do not accomplish this understanding through an argument by analogy. The other's emotion is constituted, experienced, and therefore directly understood by means of an embodied simulation producing a shared body state."*

In a previous paper (Palmquist, 2017), I put forward the idea that there might be an idea, or even an ideal that we as the therapists at all times should not disclose our emotions, a phantasy of being untouchable. After all, Freud (1927) himself once stated that: *"it is not greatly to the advantage of patients if their phy-*

sician's therapeutic interest has too marked an emotional emphasis? They are best helped if he carries out his task coolly and, so far as possible, with precision". In my paper, I argued that this is not possible. The patients constantly scan us and they seem able by the mechanisms described in this paragraph, to "read" us whether we like it or not.

Back to Clinical Reality

According to Bauer (2005), the affective charge of an abusive perpetrator is so strong that it becomes transmitted to the victim, whose own feelings become overrun and over-ruled, as if an alien force now operates from within the victim. Remember the patient who said, *"Granddaddy did not come to me, I went to him"*. So, the idea of something wicked inside them, might not, after all, be that delusional!

Indeed, a degree of pervasive shame might result from this. The patient is convinced that he/she is the one to blame – extremely afraid of disclosing her/his innermost thoughts – as doing so might result in being expelled by society, looked upon as a pervert, or a genuinely sick individual having done the most shameful deeds ever. Abuse is close to an abyss!

One female patient reported – in a voice lacking emotions – how she was in a state of utter despair, crying, and she was trying to be forgiven by her father because he could not penetrate her, she was too narrow, too tiny. Here, we find that, as the result of often-overwhelming experience, the patient has an inability to say "No", the feeling of being at somebody else's mercy; always "lining up" to the demands of the other.

The Mirror Neuron System, in all its complexity, has a formidable potential to explain what takes place between the patient and therapist (Palmquist, 2017). If the therapist has a 'good enough' self-knowledge, it could be possible – using these transmitted feelings – to understand more of what happened to the patient. In my experience, victims of early abuse can often 'induce' all kinds of disturbing possibilities, arousing fantasies and feelings in the therapist. However, what might apparently be incest might not be so sexually charged. Could it be that the adult had 'loved' the child, or the patient had approached the parent in a desperate effort to please, or to 'repair' in the 'Kleinian' sense: the parent would then have been transgressing the incest boundary, instead of understanding the despair of the child. As a result, the patient could possibly feel as ashamed – but would not be transmitting the so-called 'typical' sexual "counter-transference". The significant variable here seems to be the level of the sexual charge emanating from the perpetrator and how that was subsequently carried by the patient.

Of course, we may find other instances, such as the 'Zeitgeist'. Back in Freud's time, in the Victorian epoch, sexuality was not publicly discussed and the idea that middle-class parents could abuse their children sexually was simply preposterous – so much so that Freud denied his patients' experiences and developed the Oedipal complex instead (Masson, 1984). Also, physical abuse – as a legitimate punishment – was widely accepted. What is the difference to a child?

The Exorbitant Loneliness

Another difficulty could be the inability of the therapist to *share* the patient's world – resulting in a lack of empathy, bewilderment, all kinds of more or less ingenious interpretations, anxiety, and a feeling of being not that skilled at conducting therapy. The *loneliness* mentioned above is a product of this lack of *sharing*. A survivor of (say) a concentration camp has experienced something so absolutely abnormal that their words cannot serve to

describe it; they don't have words for it. The emotional impact of their story is also potentially devastating to the listener; it is simply not understandable – meaning that it is not possible to share, unless you – the therapist – possess a 'good enough' capacity for containing and receiving an adult person, who is experiencing disintegrating emotions, or who might fear that the story will simply destroy the listener. Often abused individuals can also feel a tremendous shame (often imposed on them by the abuser) – a fear of being exposed and of suffering the consequences, thereby also potentially destroying their family, losing their home, and being thrown into jail or worse. It is frequently the case that the perpetrator may have forced them to promise never to tell, or simply threatened them if they ever told. One patient had convinced herself that, by entering therapy, she had pointed herself towards a possible self-betrayal.

One Implication of Having a Mirror Neuron System (MNS)

The Mirror Neuron System makes it possible to share our experiences, as it makes us sensitive to the cues of communication that are provided by others. What happens if somebody, having gone through almost imaginable experiences (i.e. a severely abused patient), is *a priori* reluctant to tell, overcomes her fear and begins to do so? Let us also assume that the therapist is a well-integrated person, having a secure attachment, a normal upbringing, nice parents etc., and has never, ever, been subjected to sexual (or any sort of) abuse and as having absolutely no experience of conducting therapy with abused patients. The patient starts to tell their story – so, what would be the reactions of the therapist? The patient's MNS notes that the therapist is … unfamiliar with what she tells; nods at "wrong" places; uses a voice that is probably, either overly understanding, or not resonant with her (the patient's) feelings; – possibly also noting astonishment, tenseness, bewilderment, scepticism (Therapist: *"Could this really be true?"*). So, she (the client) hesitates – making the therapist frustrated or misunderstanding further – and so the process of the therapy becomes slower, or stops completely. One way to cope with this might be that the therapist quite flatly tells the patient, *"Listen – I am not familiar with what you have been forced to endure – so please help me to understand"*, which should be said absolutely honestly. This is much better than faking a semi-understanding: eventually, our therapist will get used to this material, becomes capable of handling her/his emotions, and has become seasoned!

But – I have also found that group therapy, where our abused patient meets sisters (or brothers) sharing the same background, might be of considerable help. The possibility to share, and to meet someone else who has had first-hand experiences, might be comforting, lessening the fear and the shame: in effect, *"I am no longer alone in the world"*: as in a band of brothers at war, we are now sharing the horrors.

Memory and Recent Neuropsychological Research

In recent years, a debate has raged concerning the possibility of memories becoming repressed. Space does not allow for any deeper discussion here, however I can provide a link to a discussion by Kihlstroem (1997). The essence of that paper is that we have two kinds of memory, explicit and implicit. In defining these, he writes that explicit memory is conscious recollection, as evidenced by the individual's ability to recall or recognize some event from his or her past. Implicit memory,

by contrast, refers to any effect of a past event on the person's ongoing experience, thought, or action, independent of conscious recollection. Accordingly, Terr (1991) argues that *"people can reveal, in their behaviour, memories of traumatic experiences that are not accessible to conscious recollection and verbal report"*.

Bessel van der Kolk, in collaboration with van der Hart (1991), when writing about Pierre Janet's work, maintains that:

> *"For the past 75 years, psychoanalysis, the study of repressed wishes and instincts, and descriptive psychiatry, virtually ignored the fact that actual memories may form the nucleus of psychopathology and continue to exert their influence on current experience by means of the process of dissociation... Lack of proper integration of intensely emotionally arousing experiences into the memory system results in dissociation and the formation of traumatic memories... Though subconscious, they continue to influence current perceptions, affect states, and behaviour; they are usually accessible under hypnosis."* (pp. 426, 431-432)

During an intense emotional experience, the individual loses the usual bearings because time as measured by the clock has ceased to be (Blanco, 1988). Recent neuropsychological research seems to indicate that memory of such episodes is state-dependent (Radulovic, Royce & Ortony, 2018). The degree of accessibility of such states might be decisive when it comes to the question of what might be looked upon as 'normal' and what should be looked upon as pathological.

Another important field of research is related to the co-play of brain regions. Raichle (2001) conceived of a *Default Mode Network*, *DFM*. It may be described as *"a set of regions more active during passive tasks than tasks demanding focused external attention. One hypothesis is that the default network contributes to internal modes of cognition used when remembering, thinking about the future, and mind wandering"* (Buckner, 2013). According to Lanius (2021), speaking about the DFM: *"brain regions are sparsely connected before 9 years of age"*. The implication of this is that "psychic dramas" during childhood may affect the development of the DFM; and – consequently – the formation of a 'Theory of Mind' – an internal handbook or map of strategies: how to think, how to react, how to behave, how to ... etc. Maybe this can amount to navigating in a maze? The patient described in Vignette 5 just did not understand how to behave among "the humans" since she did not belong to "them" ('mankind' was a too abstract concept for her).

The Author's Position

My own position in this tends to run along with the above. The concept of dissociation implies that what we experience is stored in separate files. Imagine a railway, where the parallel tracks are separated by a wall. The more or less "normal" person is aware of these parallel tracks (or more), the wall is usually permeable by will. Sometimes, when overwhelming situations hit us, the permeability lessens, to the point of hindering access – in order to keep the balance of the psyche.

However, almost anything even remotely connected to the original trauma might trigger a sudden access to repressed memories – becoming extremely disturbing, or surprising, possibly even unintelligible. This presupposes a certain internal pressure.

We remember situations that are significant to us; what is significant is personal. If the emotional level rises above an individual default – we register it! Following Damasio, emotions make us aware! We usually are able to recall what happened in sharp detail, as if the situation was recorded on both audio and video. I bet that you can recall situations that – in

life – are significant to you – such as seeing your loved one for the first time. Or, when you were about to crash on the highway. Or when ...

But, for some occurrences, memories are beyond access! So, *accessibility* is a major variable. I hold to the idea that repression exists. But not sufficiently strong as to delete memory. However, some memories linger on, in the form of psychical symptoms; in hypnosis, we call these *enactive*. Probably, this is the same as implicit memories. An example is that of the older man shaking his head, as if he were to ward off a slap in the face. A tic! If you point this out to him, he is surprised. If you tell him what it looks like, he might even look a bit bewildered. If you ask him if he was ever beaten – maybe he will tell you: *"Well my father used to hit me"*. Probably, he will not show any emotional reactions. However, if this man were to enter into psychotherapy – the emotions would catch up. Does this mean they are repressed? Or dissociated? The body therapists know that putting patients into different stress positions may elicit strong emotional reactions. Arthur Janov (1970) discovered that emotions once hindered would surface if the patient was requested to put himself in awkward positions (i.e. so as to make breathing difficult).

Using Altered States of Consciousness (ASC)

If the therapist wants to use methods based on ASC, it must be established that the patient has an inner structure of such strength that the patient can contain difficult experiences. Patients, who have relied on dissociation for survival, often have an ambivalent attitude to their trance states; on the one hand, an ASC helped them to cope with the overwhelming, the painful; but – on the other hand – it might be interpreted, on the inner scene, as if you have surrendered to a stronger power, an external force. The tendency to the so-called traumatic perception might come to the fore.

Until the attachment process has led the patient back up to a secure level, he/she is in some danger, by default. It can be extremely frustrating for the therapist, to be scrutinized and called into question, even after years of dedicated work.

I have found *EMDR* useful (Shapiro, 1987). However, in spite of the opinions held by advocates of *EMDR*, I am of the opinion that there is a clear ingredient of hypnosis. The delineation of the attention span, the focussing, maximizing the default network (Raichle *et al.*, 2001) inducing an ASC, initiating a search for cues within, etc., thereby regulating the level of arousal. But trance states vary in depth – initiating a session of *EMDR* usually means a rather light trance state – however, if the patient catches on to what might surface, a deeper state may be reached!

Neither *EMDR* nor hypnosis, or even psychodynamic psychotherapy should be used as therapeutic techniques. Instead, they should be used as "alternative means of communication", special ways developed in order to work with psychological problems. The patient should meet a genuine human being, not some kind of industrial robot trying to maximize the clinic's throughput.

What Can Prompt the Patient to Give up her/his Soul?

In 2003, I wrote: *"The deep longing / need for mother's body and soul is then exploited by the perpetrator."* Today, I would talk about an extremely strong drive or need for attachment. A child will do almost anything to preserve the bond with their significant Other. The shame that so often permeates the victim has its breeding in the experience of never having received enough unconditional love. This

abysmal sorrow – as it comes to the surface – must be contained by the therapist, who also must offer her/himself as the receiver of the patient's primitive love, as well as the almost bestial anger which is connected to the loss – finally helping the patient to understand (or at least contain) all this. It is this immensely strong need for love, and making amends for the loss, that makes us susceptible to a form of corruption by "selling our souls", surrendering to the abuse or to the perpetrator.

The therapeutic process is usually quite time-consuming – attaining and consolidating a more secure base for the client takes time. The inner world of the patient has to be almost totally re-built. This requires the therapist to be able to shift roles – firstly, by becoming a good-enough 'parent' to the small, inner child of the client, and then, eventually, supporting the development of the child into an autonomous adult. Christopher Bollas' (1987) idea of a *transformational object* comes in quite handy here!

Concluding Remarks

Trauma has been somewhat unfairly treated by psychoanalysis. The time has come to integrate findings from the growing body of neurological findings concerning attachment and psychic development in general, as well as human reactions to overwhelming situations. Freud's theory of 'conflict' has its value, but so has the modern theory of trauma – 'cross-breeding' these two should prove fruitful. The importance of the therapist's persona should never, ever be underestimated. He/she must provide that secure base that the patient never had. If you want to dive into troubled waters, the diving board must be solid!

Author

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Affirmation: The identity of all patients has been obscured, so as to maintain confidentiality. Furthermore, the vignettes being presented are excerpts from psychotherapeutic encounters more than 30–50 years ago.

Endnotes

1. **Author's Note**: This paper is a majorly revised version of a paper published in 2003 in "*Insight*" (Swe: *Insikten*) [today: *Psychotherapy*], a journal of the "Riksföreningen Psykoterapi Centrum" RPC, [Swedish Association Psychotherapy Center], 2003, Vol. 2, p. 51-60. However, I have decided to keep the introduction unaltered as it reflects sentiments and thoughts circulating 17 years ago, well before the disastrous events in the Middle East, terror bombings and the accompanying flows of refugees. The paper is meant to be used as a possible point of departure for discussion – in no way presenting the final words!
2. The **"Estonia" disaster** was when the MS Estonia sank in a storm in 1994, in the Baltic Sea, with 852 lives lost, constituting the second worst maritime disaster of the 20th century, losses during the Second World War not included.
3. This patient was considered dangerous, intermittently suicidal, impossible to treat within regular Youth Psychiatry and so she was transferred to a 'heavy' psychiatric ward when aged 17. What seems to have made an attempt at psychotherapy conceivable was probably the following incident: At our first meeting, she tried to set fire to the carpet in my office, then she rushed away; and as she went "AWOL", I managed to get hold of her with one hand – whereupon she bit me. This made me pat her cheek (I still do not know why; maybe I saw a little terrified girl?) with the other hand – which made her look at me in sheer astonishment. She let go of my hand and fled back to the ward, crying deeply upon the return. After this episode, we met 10 times – characterized by her being mute most of the time. Shortly after that, she was transferred to another hospital thus disappearing from my "radar". Some 10 years went by, until I was awakened in the middle of the night by a call from an emergency room. The doctor in question was radiating a complete helplessness, "Could I please help them". The hospital staff had found a note in her clothes with my personal telephone number. She had kept track of me! She had arrived escorted by police after having bitten a bus-driver. So, we met again and started a psychotherapy that ultimately lasted 14 years. Authorities in the field, such as Lewis Wolberg (1990), who led a seminar in which I sought supervision, considered the patient completely untreatable. Our long contact was indeed paved with huge difficulties. But the patient eventually could leave psychiatry, since living a rather long and normal life

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A Pragmatic Framework for the Supervision of Psychotherapy: Part 3: Socratic Exploration

James C. Overholser

Abstract: The supervision of psychotherapy is best viewed as a collaborative process aimed at solving problems related to each client's struggles. For the problem-solving process to function effectively, the supervisor should have an adequate amount of clinical experience and clinical expertise to serve as a proper guide. Despite their clinical expertise, supervisors should remain modest about their own knowledge and ideas in order to solicit input from trainees. The supervisory process relies on a systematic series of questions to guide a collaborative search for ideas that can result in a refined strategy for therapy. In addition, the process promotes self-improvement in trainee, encouraging self-awareness and self-evaluation of all aspects of psychotherapy.

Key Words: supervision, psychotherapy, Socratic method

The supervision of psychotherapy aims to protect the client and enhance the professional development of the trainee. There are at least four main components to effective supervision, including educational guidance with specific directions, a supportive alliance with an experienced therapist, a collaborative process of exploration and discovery, and specific approaches that are adapted to the unique situation created when responsible for supervising different trainees and their clients (Overholser, 2004).

Some types of supervision rely heavily on didactic training to teach specific psychotherapy strategies. This directive guidance can be useful during the novice stage of professional development. However, as the trainee gains experience, less directive approaches are appreciated. Instead, trainees can be helped to path explore different ideas and new strategies (Feinstein *et al.*, 2015).

The Socratic method can be used to guide psychotherapy sessions (Overholser, 2018) as well

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as supervision meetings (Overholser, 1991). When used in clinical supervision, Socratic exploration can help explore psychotherapy strategies and promote independent problem-solving skills in the trainee. The process of Socratic exploration relies on several steps (see Figure 1). The present paper explores Socratic exploration – as it can be used to guide the supervision of psychotherapy.

Clinical Experience of the Supervisor

In order to serve as an effective supervisor, the professional should have an advanced degree in a mental health field, prior supervised training in psychotherapy, and ongoing experience providing the clinical services they intend to supervise. Experience does not guarantee wisdom, but wisdom is built upon actual experience (Jennings *et al.*, 2003). It is important for professionals who teach graduate courses on psychotherapy and supervise graduate students in their clinical services to develop clinical expertise (Overholser, 2010) and remain active in the direct provision of those same services (Overholser, 2019). These credentials lay the foundation for the supervisor's credibility, improving the odds that their clinical insights will be useful and will be accepted by the trainee. Furthermore, developing expertise in psychotherapy most likely requires 5-15 years of active practice (Jennings, 2003; Ericsson, 1993).

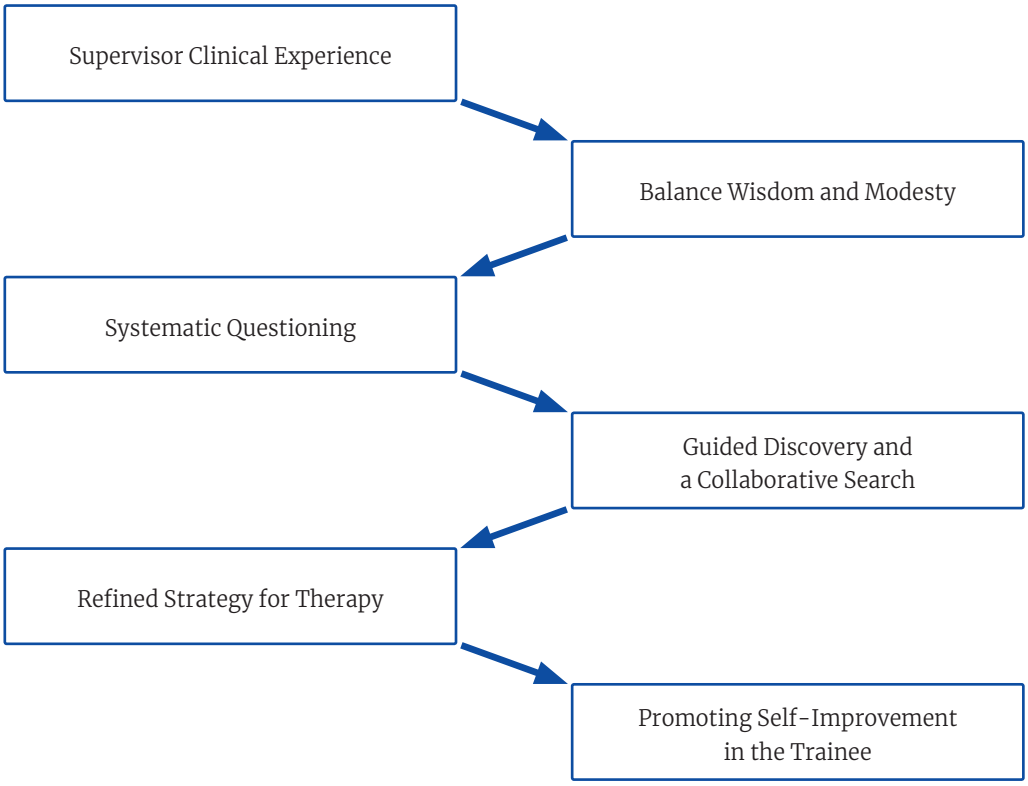

Figure 1.

Balancing Wisdom and Modesty in Supervision

A supervisor needs to balance wisdom and modesty. The wisdom derives from their academic credentials and years of accumulated clinical experience. However, their intellectual modesty derives from a philosophical respect for ambiguity in most situations. There are usually multiple ways of interpreting an event, and most situations provide only a restricted view imposed by limited access to information. It can be helpful to respect the supervisor's distance from the "front lines" of psychotherapy. In many ways, clients are the experts, knowing the details of their own life and struggles. The supervisor may highlight the view that the trainee has been doing the front-lines work with the client, allowing the trainee access to those subjective elements of therapy that can only be experienced during face-to-face meetings. Further, clients are the experts in terms of knowing their own life events, their own natural inclinations, and knowing the people in their social network. Thus, the supervisor remains a further step removed from the immediacy of the session, but brings a helpful view as an objective outsider.

Supervisors can reduce the power differential (Watkins *et al.*, 2016), minimizing their own status as teacher or expert. Especially when working with advanced trainees, questions can be used to solicit their input and encourage their leadership in treatment planning (Enlow *et al.*, 2019). Intellectual modesty includes a willingness to admit that knowledge is often incomplete or flawed, and most professionals benefit from a lifelong search for new information (Overholser, 1995). Supervisor modesty includes an openness to uncertainty (Silva & Sousa, 2018), respecting the lack of certainty whenever evaluating client problems or predicting client behaviour.

Modesty or humility includes a willingness to recognize and admit to one's mistakes, flaws, and limitations (Watkins *et al.*, 2019), including mistakes made during supervision (Watkins *et al.*, 2016). In a survey of 496 graduate students enrolled in marriage and family therapy graduate training programs (Anderson *et al.*, 2000), trainees reported that supervisors were willing to admit their own areas of rigidity or weakness six times more often in the best supervision (62.0%) than in the worst supervision (10.7%).

A lack of modesty can have a destructive impact on the supervision (Ladany, 2014). In many ways, intellectual modesty comes easily when a supervisor remains active in the direct provision of clinical services. Any clinician can appreciate the difficulties and challenges of providing effective psychotherapy, especially when some clients display signs of resistance, personality dysfunction, or chronic patterns that date back to an early developmental period. Keeping these challenges in mind can soften a supervisor's expectations and enhance a supervisor's insights into common clinical problems.

Use a Series of Questions to Guide Supervision Meetings

The stages of problem-solving can provide a useful framework for psychotherapy (Nezu & Nezu, 1989; Nezu *et al.*, 2013) and for clinical supervision (Overholser, 1991; Cummings *et al.*, 2015; Wasik & Fishbein, 1982). A survey of 102 psychology interns viewed the ideal supervision as involving supervisors facilitating problem-solving skills in the trainee (Gandolfo & Brown, 1987). As part of the Socratic exploration, the supervisor uses a series of questions to discuss the recent session, identify psychological factors that may be central to the client's struggles, and explore various strategies that could help improve upcoming

therapy sessions. The supervisor uses a series of questions to facilitate the exploration of ideas and options (Overholser 1993).

Questions can also be used to guide the flow of a supervisory meeting (Moffett, 2009). Each question should reflect a genuine search for new information, asking the trainee to think about the psychotherapy in a new and useful manner. For example, supervisors can ask their trainees: *"How did the session go?"*; *"What did you think went well?"*; *"What do you wish you had done differently?"*; *"What is your working diagnosis?"*; *"What evidence supports your diagnosis?"*; *"Are there other diagnostic categories that deserve a closer look?"*; *"Aside from diagnosis, what do you see as the core issue?"*; *"What strategies might help you to really focus on this core issue?"*; *"What do you hope to address during the next session?"*; *"Thinking long term, what is your ultimate goal for this client?"*; *"Thinking short-term, what is your plan for the next session?"*; *"Can you see a path to the other side when this issue is no longer a problem?"*

It should be noted that not all these questions would be used in a single session. It is important to avoid creating the feeling of an interrogation. Instead, the supervisor wants to express a sincere interest in the flow of therapy and a genuine desire to help the trainee provide high quality therapy.

Not all questions are compatible with the Socratic method. Each question should pose a sincere search for new information. It does not help to ask questions for which the supervisor already has an answer in mind (Guiffrida 2015; Mehan, 1979), because it changes from a search for information into a 'pop' quiz with right and wrong answers (Mehan, 1979). Also, useful questions are guided by a sincere search for information and ideas, and should not present a hidden directive. Thus, a question that presents a recommended alternative, framed in the form of a question, really conveys the supervisor's directive. Such common leading questions include: *"Have you considered switching to a mindfulness-based approach?"*; *"Have you considered using behavioural activation to help your client become more active?"* A "question" like this is not a genuine question. Instead, it presents a recommended strategy, and seeks compliance from the trainee. These "questions" imply direction, but without openly stating the end of the statement *"... because I think it would be helpful"*. Socratic questions search for information that might be useful for both the supervisor and trainee. Thus, it would be more genuine to ask a trainee: *"How do you think your client might respond to behavioural activation strategies?"* or *"Do you think behavioural activation could get your client moving in a more helpful manner, or would it be too difficult and become another failure experience for the client?"* These are sincere questions that seek the trainee's input and expectations. Depending on the answer, the supervisor could continue, asking *"If you try using behavioural activation in the next session, what would it look like?"*, or *"How would you explain it to your client in a way that fits their personality and their pathology?"*

A problem-solving framework can help trainees to make sound decisions based on logical reasoning (Cummings *et al*., 2015). Questions can be used to guide the trainees through a process of rational decision-making. For example, trainees can be asked: *"Moving forward, what do you think is the best plan?"*; *"What is your best guess, how effective will this be?"*; *"If you make this shift, how do you think the client will respond?"*; *"As we sit here now, what do you anticipate might be the hardest part for you as therapist?"*; *"What can be done before the next session to help you get ready?"*. Each of these questions can help to push the trainee forward, encouraging a plan and rational decision-making, but without implying the supervisor's choice of direction. Useful questions

solicit input from the trainee, which is essential so the trainee is allowed to select treatment strategies that align with the trainee's own strengths and personality style (Maruniakova *et al*., 2017).

Guided Discovery and a Collaborative Search

The Socratic method can facilitate a collaborative approach to supervision. The Socratic method relies on an inductive search for ideas (Overholser, 1993), assuming that each client presents with a unique set of background life events, personality tendencies, and current life circumstances. Guided discovery (Overholser, 2018) includes an inductive search for persistent themes and recurrent patterns in the client's struggles.

Socratic exploration can help supervisors to work collaboratively with trainees as part of a joint search for ideas and strategies that might be helpful with a particular client. At times, the supervisor may act like an experienced tour guide who knows the area and offers advice for a productive exploration. The guide has years of experience, but respects the preferences and intentions of the trainee, facilitating a collaborative process of exploration. The guide knows the terrain, the best hiking trails, the optimal fishing spots, and the dangerous areas and dead ends. As a guide, the supervisor is willing to travel to new terrains together (Guiffrida, 2015; Mahony, 2003) while gently steering the exploration down safe and useful paths. The guide offers advice about the best destinations and useful directions, while also warning about dangerous routes or likely dead ends.

Socratic exploration is a slow process that requires a fair amount of patience. It can seem much faster and more direct to simply give the trainee direct instruction, taking a strong lead in the case conceptualization and treatment planning. However, the use of Socratic exploration promotes the trainee to leader of the therapeutic decision-making process and helps the trainee take ownership for the style and focus of the therapy.

Refined Strategy for Therapy

Case conceptualization and problem definition are key elements to effective planning in therapy. Case conceptualization is one of the more advanced and complex skills to learn in supervision (Liese & Esterline, 2015). Trainees can be asked a series of questions designed to facilitate a thoughtful conceptualization of each client's struggles. Questions can be used to help trainees generate a variety of strategies for helping their clients. For example, trainees can be asked: *"Based on our discussion today, what might you do differently than last session?"*; *"Let's look at it from a different perspective, how might Sigmund Freud look at this client's struggles?"*

The supervisory meeting can explore appropriate goals for future sessions, setting deadlines for resolution or termination, and confront any need to change the style or focus of therapy sessions. Useful questions can include: "*What is your plan for the next session?*"; *"Can you see a 'master plan' for the next 10 or more sessions?"*; *"Can you see a plan that links these various issues together?"*

Trainees can learn to define the problem by identifying the main priorities to be addressed in therapy, keeping a clear focus on psychological processes. Throughout the case conceptualization, the supervisor guides the trainee from a broad biopsychosocial overview toward a focus on the core psychological issues that can be addressed through psychotherapy. In most situations it is useful to rely on a comprehensive bio-psycho-social model, whereby the therapist collaborates with a social worker or a psychiatrist to address issues

related to social services or biomedical treatments. Some trainees are drawn to the current emphasis on psychotropic medications or innovative biomedical strategies. If the client seems to struggle because of biomedical reasons, the therapist can make a referral to a qualified psychiatrist who may be able to prescribe psychotropic medications or recommend hospitalization. If the client seems to struggle because of social issues, the client can make a referral to a social worker who may be able to help with subsidized housing, job search platforms, or financial aid. Thus, the supervisor can keep the treatment plan focused on identifying core psychological issues relevant to the client's psychiatric diagnosis, searching for recurrent themes and patterns of dysfunctional behaviour. The plan for treatment can focus on underlying psychological issues related conflict, loss, failure, acceptance, competence, or interpersonal relations. However, trainees often need guidance to look beyond current events and recent stressors, sidestepping the weekly problems reported by many clients. Finally, many trainees need to step away from a pressing desire to quickly reduce the client's subjective distress and instead focus on understanding the client's struggles from inside the client's own unique subjective phenomenological experience.

The supervisor can use a series of questions to help the trainee identify and "dissect" the client's problems. For example, a supervisor can ask: *"I know it is early, but what is your current working diagnosis?"*; *"What evidence supports your diagnosis?"*; *"I'm not disagreeing, but to be thorough, we should look to see if there are any other diagnostic categories that deserve a closer look?"*; *"What other diagnostic problems might be relevant here?"*; *"Aside from diagnosis, what do you see as the core problem that needs to be addressed?"*; *"Do you feel this issue is central to the client's ongoing struggles?"*; *"What will you do to address it in future sessions?"*; *"What strategies might help you to really focus on this core issue?"*. After several useful strategies have been identified, the supervisor can help trainees to evaluate options and make rational decisions (Cummings *et al.*, 2015).

A psychotherapist should retain a strong and clear focus on psyche, emphasizing changes in the mind and mental processes. The supervisor can use a variety of questions to help the trainee begin to identify goals for upcoming sessions. Too often, trainees are reluctant to dig deeper into the client's psyche, preferring to remain on a safe but superficial level. Occasionally, the supervisor may share an analogy that can help expand the trainee's understanding of a client's struggles (Overholser, 1993). For example, the supervisor can explain an analogy of a deep wound that has not healed properly, leaving (emotional) scars or a deeper infection. Some clients apply a simple bandage, hoping for a quick healing process. However, if the wound was contaminated and it was never properly cleaned, infection will develop and the wound will fail to heal. To promote proper healing, the bandage must be removed and the wound must be cleaned, even if it causes acute pain. To minimize the risk of further infection, the deep cleaning should only be performed in the sanctity of a sanitized clinic. In many ways, clients have emotional pain that has failed to heal over time. In order to promote true recovery, the therapist may need to open the emotional wound and probe deeper into their upsetting events, knowing that is may temporarily hurt the patient, but with the plan that it will clean out the painful memories and allow for lasting improvement. However, before the session ends, it is important to sterilize and re-bandage the exposed area.

Promoting Self-Improvement in the Trainee

A primary goal of supervision is self-improvement in trainee's knowledge and skills. Professional development relies on accurate self-awareness and self-evaluation, being aware of personal strengths and weaknesses as a therapist. Thus, it may be best to view professional development as a lifelong task.

Supervision can facilitate self-reflection (Bennett-Levy, 2006). Trainees can be asked to complete writing assignments to help guide their own periods of self-reflection (Moffett, 2009). Self-evaluation lies at the core of self-improvement (Overholser, 1996). In order to protect the quality of therapy sessions and continue to improve, the therapist should be reviewing their own work and identifying areas of strength and weakness. In supervision, the trainee can be asked to review and evaluate each session, highlighting both the positive and negative aspects of the session.

The supervisor can use a variety of questions to guide the trainee's self-evaluation of each session. For example, supervisors can ask: *"How did the session go?"*; *"What did you think of the last session?"*; *"What did you think went well and seemed useful for therapy?"*; *"Was there any part of the session that did not go well?"*; *"What happened there?"*; *"Do you think you could have handled it in a different manner?"*; *"What would you have liked to have done?"*; *"What do you wish you had done differently?"*

Throughout the Socratic exploration, supervisor and trainee collaborate on ideas, plans and strategies for upcoming therapy sessions. The supervisor does not expect blind compliance with specific instructions but encourages independent problem-solving in the trainee. Most supervisors prefer trainees who think independently instead of simply repeating instructions provided by the supervisor or a training manual.

Self-improvement relies heavily on the trainee's objective self-evaluation, an essential skill for lifelong development as a clinician. It can be useful to push the trainee to view sessions from a different vantage point, asking *"If your client goes home and has a personal and private chat with her best friend, how would she describe today's session?"*; *"Would she tell her friend that she talks and complains about all kinds of things while her therapist simply listens?"*; *"How will you know if the client has improved?"*; *"What will tell you when the sessions can be terminated?"*; *"What will it take to be sure your session become obsolete?"*; *"We do not want your client to depend on you for endless support. We do not want the sessions with you to be the only time someone actually listens and supports the client."*; *"How will you know if the client has improved?"*; *"What do you think your client is getting out of these sessions?"*; *"Based on our discussion today, what might you do differently than last session?"* A variety of questions like these can encourage trainees to evaluate their style, focus, and content of a recent therapy session.

Ultimately, supervision is a process that is designed to facilitate the self-improvement and professional development of each trainee. The supervisor is invested in the personal and professional growth of the trainee. As part of a short-term perspective, the supervisor can help trainees look to the upcoming therapy sessions and develop a thoughtful plan for therapy. The supervisor can guide the trainee toward becoming an independent professional, capable of functioning well, even with limited supervision.

Discussion

Becoming skilled in psychotherapy supervision can be a long and convoluted process (Gazzola, 2013; Goodyear, 2014). However, clinical supervision is an important and rewarding process. The supervisor has opportu-

nities to provide high quality therapy via the trainee's work as a clinician. In addition, the supervisor has a responsibility to promote the professional develop of the trainee. The process of Socratic exploration can help supervisors to attain both of these goals.

As pertains to clinical supervision, the Socratic method includes a strong use of systematic questioning, inductive reasoning, intellectual humility, and a focus on self-improvement in the trainee. The Socratic exploration requires trust in the trainee's ability to think through complex clinical issues. Thus, the supervisor provides guidance that can help the trainee to think, reflect, and improve the plan for treatment.

The Socratic method is an abstract and philosophical venture. It is best used in limited dose and brief segments within a supervisory meeting. If the supervisor relies on an extended list of questions, the meeting may feel like an interrogation. However, when incorporated into a broader framework for supervision, Socratic exploration is central to refining the intellectual processing of the trainee's case conceptualization.

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Screen Relations in Practice – A Reflection on Rupture and Repair

Ronen Stilman

Abstract: The psychotherapy community has undergone a dramatic shift in the way that psychotherapy is delivered, supervised and taught, in response to the recent Covid pandemic. The discourse and narrative about working online has often focused on its limitations rather than possibilities. In this essay, I consider how our relationship with technology shapes our perception of working online and offer some practical examples that will explore what could be gained by paying attention to some of the new information available when working online, and how it could be incorporated into practice.

Key Words: attachment to technology, working online, COVID, unconscious process

The ongoing battle with the Covid-19 pandemic has had a fundamental impact on how we work and relate. It had an abrupt, sometimes shocking, unexpected impact on our day-to-day, and on our sense of safety and connection. The need to minimise the spread of the virus led to prolonged periods of "social distancing" and repetitive cycles of going in and coming out of varying degrees of "lockdown", reflecting a shared language and experience of instability and threat that led to changing the way we make contact in our daily lives. Screens have become central to how we relate as *"Something has shifted in our relationship with technology... We have changed as individuals and as a society through the experience of lock down, and as the corporal world does not feel safe or predictable, the online alternative can seem more manageable"* (Stilman, 2020b, p. 50).

A recent post by one of the most visible therapists in the world, Esther Perel, seems apt as a frame for this article. *"As zoom has replaced in-person sessions – and this could go on for some time – we decided to pack up. And so, after 15-years, I said goodbye to my office mates, or daily coffee breaks, and the gorgeous city views from the 22nd floor"* (2020). I found that this social media post marked this shift, portraying a new channel our profession is struggling to adopt.

This experience has thrown us into turmoil, as individuals and professionals. What has begun

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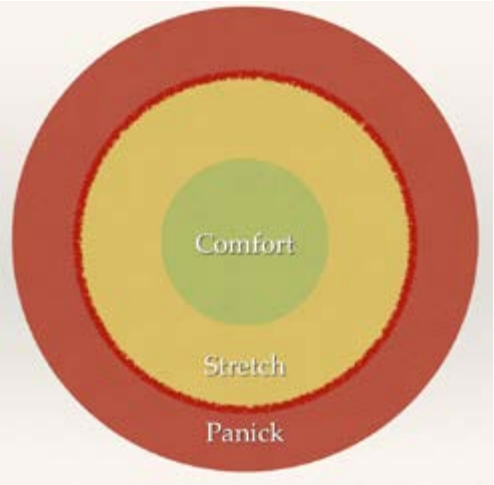

Image 1. *Our Edge – adapted from Vygotsky (1978) and Senninger (2000)*

with a reluctant shift to working online has turned into a sustainability question for practitioners and organisations. With that shift, a debate emerged about the perils of working online which often felt to be on the verge of catastrophe with a dash of Greek tragedy – a very apt genre given the circumstances. The underpinning great loss of daily physical contact and working face to face, raised a question that seem to surround on the superiority of face to face working in comparison to working online. However, is it at all comparable? And might we lose sight of the value of a different alternative?

In my work as a supervisor and educator, I have seen a growing disparity in the way that practitioners and organisations providing critical mental health services and placements adapted to the situation we were facing. Through many conversations, I experienced some practitioners and leaders in the community going into a very scared place, sometimes to the degree of freeze and shut down. Bollas noted that "*In our era, the disparity between degrees of access to new forms of technology create a widening gap between those who are employing these prosthetics extensions of the self and those who are not, and are thus potentially disabled*" (2018, p. 54). As someone who is deeply invested in the survival of the professional, I wish to develop a better relationship, language, understanding and theory that supports us practitioners in this age of bewilderment. As Darwin put it, it's not the survival of the fittest, but the survival of those who adapt.

How might we integrate this new experience into learning? Vygotsky describe the zone of proximal development as "*those functions that have not yet matured but are in the process of maturation, functions that will mature tomorrow but are currently in an embryonic state*" (1978, p. 86). I believe it is fair to say that this quote reflects our understanding of screen relations. Senninger outlined a model for learning: comfort, stretch and panic (2000). I am particularly interested in the boundary between the stretch and panic which is where I think our edge is. The edge is where our relational frame is disturbed; where we are on the boundary between connection and disconnection from our self and other. It is also where learning, growth, change, conflict, rupture and repair take place. Panic is where we have moved out of our window of tolerance into a threat response, and our capacity to think and relate is impaired (Siegel, 1999).

The circumstances that we have found ourselves in when working online has threatened the fundamental pre-suppositions of how therapy, supervision and learning of these is conducted. Two key aspects have been challenged: the first one is the absence of the corporeal presence, which for those who were not used to working online before, is often experienced as a rupture. Is that to be without repair? The second aspect is that as we can no longer expect to meet in our practice, our space, but rather in Cyberspace, a co-constructed, virtual space that emerges in its most literal sense,

our room as a practitioner's, as well as our counter-part: clients, supervisees, students.

When it comes to working online the narrative and discourse seems to have been limited to technicalities. I would like to expand this discourse and narrative beyond technology and the tools that might be used; beyond the important ethical and legal requirements that need attended to such as data protection and confidentiality. What I would like is to return to a common basic foundation of psychotherapy practice – the use of self. Therefore, I would like to turn the lens to you as a practitioner: What has disturbed your relational frame? What aspect of online working has stretched your frame, taking you beyond your comfort, possibly into panic? One of the principles of Transactional Analysis is Berne's third rule of communication, which posits that the behavioural outcome of a transaction is determined at the psychological level, rather than the social, overt, level (1961). In essence, I am asking what, at the psychological level, that affects how you relate online, and how might that inform you about your practice?

I previously wrote about our attachment to technology and our growing reliance, dependence on, and relationship with, technology (Stilman, 2020a). Attachment is a formative process; a process that is in the core of human experience as it shapes our identity, our sense of self, and how we relate to others, which in turn, shapes how others relate to us, and consequently reinforcing our sense of self and identity. Most importantly, it shapes how safe and secure we feel in the world (Bowlby, 1973; Ainsworth, 1978). Extensive research has shown that attachment can be a process of growth, healing, and connection, but can also be a process of disconnection, one that can be hostile, scary, and even traumatic, and can leave us scarred and wounded – or sometimes avoided altogether (van der Kolk, 2014). Therefore, when it comes to working online, how might you describe your relationship with technology? I would like to offer an emerging hypothesis that there is a direct correlation between the perceived attachment style of the practitioner, and the perceived sense of their qualitative contact with their clients. Is your attachment style secure? Or might you feel anxious – ambivalent about it? Could it be avoidant – dismissive? or maybe disorganised – fearful? I am proposing that by becoming aware of our attachment style to technology, and reflecting on our sense of connectedness, we can affect change to its quality, an idea we are comfortable employing in corporeal practice.

A valuable area of exploration to illustrate this, is our posture – how we sit when working online. I've noticed that many colleagues and practitioners seem to lose contact with their posture when sitting in front of a screen, often hunching forward, forgetting to sit back into their chair, allowing breathing and ground. A question I started posing to clients and supervisees is, *"Are you sitting comfortably?"* I invite them to notice their back, their shoulders, their hands and feet, and to reflect how their posture differs from how they would be sitting if they were in the physical presence of a fellow human. I also ask them to notice the angle of the screen, as I noticed many tend to sit directly in front of the screen, and therefore, their client. This differs from the corporeal experience, as often we opt for sitting in an angle, rather than directly in opposition to our counterpart. The more natural angle not only affords the gaze to wonder in and out of contact, possibly into reverie, but also gives the eyes of the practitioner a much-needed respite from staring at a screen; a chance to refocus at differing distance and perspective.

Gibson describes, *"the affordance of the environment are what it offers … what it provides or furnitures, either for good or ill"* (1979, p. 127). What does working online afford us as prac-

titioners, and how might that affect how we relate to our clients? In a recent workshop, I invited participants to explore whether they have been wearing clothes they would never wear with a client or a supervisor. Some have been wearing joggers or shorts. Some were not wearing shoes or were completely barefooted. I invite you reflect; how might that affect how you relate? Personally, I have found that sitting in lotus pose and without shoes affords me a sense of groundedness and presence that enhances my sense of connection. I wonder whether professional etiquette would afford the same if I was to sit like this in my consulting room in the physical presence of another.

A rich source of transferential exploration often missed is the use a virtual background. I invite reflection to the thinking behind this – How was it chosen? Is it to filter a socio economical reality? Or might it be to put some distance between your personal and professional identity? What could be inferred or projected to as a result? Similarly, if you're not using a virtual background – how have you attended to what is behind you? Did you choose it, and if so how? What might be the meaning of the communication that could be stimulated? Whether you use a virtual background or not, it says something about you and will play out in the transferential domain in some shape or form.

Another interesting example is the ability to self-view – how might seeing yourself supports or interferes with how you relate? The feedback from practitioners is mixed: some find it a distraction from the present. Some see it a useful feedback mechanism that increases their awareness of how they relate. Some reported that the experience of seeing themselves with others on the same screen supported their sense of belonging in relationship or being part of a group. Yet for others, it epitomises their experience of distance and isolation of virtual connectedness. Either way, this information is useful in understanding facets of relationship that we had no access to before, and are therefore important for therapeutic work.

Until recent times the culture of psychotherapy did not consider working online as an equally effective, and sometimes appropriate, way of practice. However, the environment and the context in which we practice has dramatically changed. The most frequent struggle I hear from practitioners with regards to relating online, is about the absence of an immediate physical felt sense of the other. Edward T. Hall, a cultural anthropologist, was interested in studying how the environment affects distance between people. He defined proxemics as the interrelated observations in theories of human use of space, and considered it an elaboration of culture (1963). Berne, the founder of transactional analysis and his contemporary, was interested in how space in interactions translates to the symbolic, and incorporated this into his notion of group Imagoes (1963).

Combining these ideas, I started experimenting with language to explore and reflect on the physical felt sense of the online relational process. I found that by attending to the experience of connectedness, and allowing greater awareness of what is going on an interpersonal and intrapsychic level, a growing sense of contact and attunement emerges despite the intermediation of Cyberspace. I use the following spectrum and language to compare and contrast our individual and combined felt sense of connectedness, as per Table 1: Distance – do you experience the other as near or far? Matter – does our relationship feels fluid or solid? Texture – does the space between us feels smooth, soft or perhaps angular, or sharp? and lastly what is the temperature like – is it hot, cold, or somewhere in between?

Explicating these can be used to attend to what might need shifting in your position at

Distance	Near	Far
Matter	Fluid	Solid
Texture	Smooth / Soft	Angular / Sharp
Temprature	Hot	Cold

Table 1. *Exploring Proxemics in Practice*

a physical and psychological level. Particularly, when working online, but not limited to, this information is incredibly useful in exploring the struggle to connect, to belong, at a time that when this existential human need has been brought to a sharp challenge. This process – and its emerging data – is incredibly useful for us as practitioners, as well as our clients, in whatever the context you are working – therapy, supervision, teaching. It will provide insight and a language to enhance closeness and intimacy, by identifying areas of defence, stuck-ness and impasse to attend to.

Working online has also transformed what our clients afford. The most obvious shift is in accessibility. The limitation of distance and physical obstacles are now bound only by the bandwidth of our internet connection. Parking, stairs, elevators, as much as being in the same locale or country have become almost obsolete. The increase in accessibility is certainly a more equal offering for our clients given that they can now reach almost any practitioner anywhere. At the same time, it opens the profession to a process akin to globalisation, which often puts local trade in a much more vulnerable and precarious position.

Another shift personally experienced, and echoed by feedback from other practitioners, is that some clients are attending sessions from their car. Often, this is a choice, driven by the need for privacy from eavesdropping co-habitats, or limitation of connectivity. This situation requires careful attention to boundaries. A similar need is required when working with someone sitting either on their bed, or having their bed in the background in a way that offers a vivid window to their private life.

In her book, Russell (2015) argues that the therapeutic frame has weakened. Whilst I do not necessarily agree with this statement, it is important to consider a shift in power dynamics. The fact is that we can now see into our clients' homes and they can see into ours. We now have a window into our clients' private habitats and vice-versa, which affords rich socio-economical, cultural and interpersonal information which we would not have had access to otherwise: Are they sitting in the kitchen or in a communal room? What level of interference is experienced form other members of their household? What does the interior design and furnishing of the space reveal? In a recent workshop, Essig (2020) argued that, when working online, the client has to hold themselves rather than practitioners holding them. My sense is that this co-constructed virtual cyber space created by practitioner and client, eloquently fits with radical psychiatry ideas of power sharing and relational principle

of 'We-ness' and shared responsibility (Tudor & Summers, 2014).

Bollas differentiates between sight – what we see through our eyes – and insight, which *"involves our consciousness being directed towards the internal world, and it implies interest in the various meanings of our lived experience"* (2018, p. 63). He argues that if we focus too much on providing interpretation or analysis to our clients and supervisees, rather than asking them to reflect, digest or think about it for themselves, we can limit the effectiveness of the work. Bolas described refractive thinking as a process that *"selects a minor feature of communication and highlights it, sending the core communication to oblivion. It therefore eliminates meaning"* (2018, p. 64).

By way of parallel process, if we focus only on one aspect of relating through screens, we reduced its value, meaning and impact on our way of relating. Change process: therapy, supervision, coaching or teaching, is a liminal process, where we come out as different from the way that we came in. In that sense, we are in a process of change at a systemic level, and I would invite you to account for your liminal process with regards to screen relating.

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Therapeutic Process & Transference in Psycho-Organic Analysis

Marc Tocquet, Caroline Winkopp & Jennifer Denis

Abstract: In this article, we expand our view of the therapeutic process and of the transference relationship in Psycho-Organic Analysis. We explain what, in our opinion, the therapeutic relationship consists of in this kind of therapy. Starting from the three fundamental determinants of the human psycho-emotional development (attachment and the security process, interactivity/inter-subjectivity, and the oedipal relationship), the therapeutic relationship can be constructed around them, and it is around these three axes that the transference relationship develops. Two of the three determinants occur before the development of language. This reinforces the value of our practice as psycho-organic analysts, where body sensations, feelings, and emotions are fully considered and investigated since they are the basis of all relationships: these situations initiate subjectification, and since they are the foundation, in transference, of the process of regression, they can also bring about reparation, and transformation.

Key Words: Psycho-Organic Analysis, therapeutic process, therapeutic relationship, attachment process, interactivity, inter-subjectivity, Oedipus complex, transference, counter-transference

Introduction

Psycho-Organic Analysis is a processual psychotherapy, entrusting the client that he/she will be able to actualize in the session and in transference, the very situations that are difficult for him/her and that he/she wishes to resolve.

This way in which we trust the client means that we believe that each person has a healthy core deeply rooted inside him/herself, which tends to fulfill itself as totally as it can. This, in our view, is inscribed in a more significant movement which we call "primary impulse".

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A newborn baby expects to experience a certain number of things. It doesn't know this consciously, but everything inside itself waits to be fed, carried, and loved. It waits to be talked to, to be integrated inside a universe, to be taken care of. The baby is not inactive. The psychoanalyst Daniel Stern, notably, has shown how the baby puts into play a whole array of capacities in order to enter into a relationship, in order to create this relationship, since it is totally dependent on its environment, since it crucially needs the other (Stern, 1985).

Everything that is alive strives to exist and to develop as much as possible. This need to experience that which allows us to develop and to become ourselves as much as we can is what we call in POA[1]: primary impulse.

This primary impulse finds itself confronted to reality. Indeed, the baby, with all its potential, is born into a certain context, which is more or less favorable. Will it be the expected child who will be taken care of with love, and who will immediately find its place? Or isn't it that well expected? Or not expected at all? Its expectations will, therefore, maybe not be easily met, or even not met at all. Indeed, these different situations allow for a greater or lesser fulfillment of the primary impulse.

It so happens that the part of the primary impulse that has not been experienced remains on hold, waiting to be fulfilled. The child who has not been loved enough, considered enough, or sustained enough, always keep inside him/herself, even as an adult, these expectations alive, more or less buried deep inside. This is what, fundamentally, motivates the therapeutic process, and also what makes it work.

During all his/her life, the human being is confronted with the primary impulse. During all his/her existence, the person constantly strives to fulfill him/herself as much as possible, to develop his/her skills, his/her capacities, to embody what he/she feels he/she was born to embody.

Another way to define the primary impulse would be to say that it is what produces the terrible suffering that the individual feels when he/she cannot fulfill what he/she wishes and wants to accomplish. This pain can be very intense, it results from the unfulfillment of the accomplishment of one's subjectivity.

When one will try to accomplish one's primary impulse, one will meet different obstacles on one's way: concrete, material hindrances, due to the location, to the culture, to the period of time where and when one lives, and which don't always give the possibility for a full self-accomplishment. Other obstacles arise from relational problems: family neurosis, for example. The difficulties brought about by family structure, by unconscious movements projected unto each person, by the loyalty contracts in which the client feels him/herself, consciously or unconsciously, trapped, are elements upon which the therapeutic process may have an action.

The primary impulse is like a seeker head, which has at its disposal the whole of life energy, so that, as soon as possible, the human being will strive to accomplish him/herself. It is, therefore possible to understand that in the therapeutic process, we follow the patient in this natural movement of self-accomplishment. We follow the client's meanderings, we don't precede him/her, we don't know better than him/her, we don't know where he/she will be heading, we don't lead him/her down the path we would like him/her to follow, nor do we indicate the way we would like him/her to proceed: it is the person – who orients him/herself – unconsciously – towards what he/she needs.

What fosters the quality of the therapeutic relationship?

In the first place, something crucial is the way the patient is *welcomed*, and this is expected to allow for a good transferential and transformational relationship to be set up. When we welcome the client, we actually welcome a child who comes to see us. We warmly host the individual in all his/her richness, and his/her suffering, in his/her total subjective originality, which is what we begin to listen to.

The therapeutic relationship is the first healing factor [2]. To be listened to by someone who is as present as possible is profoundly therapeutic. Therefore, our know-how begins by the quality of our welcoming, by an open and caring, attentive, unjudgmental attitude, which allows the person to take hold of this situation and to let whatever he/she feels in him/herself, to allow what takes place inside him/herself, to emerge. It is the confidence in this relationship, the absence of judgment and the therapist's openness, who perceives the client, which allows him/her to open up little by little, to deliver parts of his/her intimacy, and to accept novelty, and the unknown.

When we say that we follow the therapeutic process, this is not to mean that we are inactive. The therapeutic relationship is also inhabited by the therapist's capacity for aliveness. We listen in a warm and active way. We let the door wide open for the emergence of bodily sensations and emotions, since we are alert to the person's unity.

One of our specificities is also that we are able to suggest to our client, according to the different situations which he/she will come across, different ways of reacting: – in particular, what we term "experientials". These experientials are ways that we propose in order to explore and to deepen a specific situation, the remainders and the effects of that situation, they are also meant to come into contact with the primary impulse. These working possibilities are manifold. Even more so, since we can adapt them specifically to the client who is present with us, to the specificities of the situation at hand, and to the moment of the process concerned.

It is, of course, a delicate matter to suggest different ways to apprehend situations, to offer work modalities. One has to measure the correctness and the pertinence of an intervention in the therapeutic space and in the transference setting. But in our experience, we have learned that when these suggestions are in tandem with the process, when they don't mistreat the client's psychic defenses, they constitute fantastic therapeutic levers, in order to change therapeutically what remains harmful, alienating, or de-subjectifying in the situations concerned.

Quite often in the therapeutic process, beyond conflicts linked to the Oedipus dilemma, it is necessary to go beyond that and to meet the young child, who is hindered, hurt, and sometimes anguished, and to allow him/her to hear what he/she has not heard, to live in the transference what he/she has not experienced, so that he/she can take up again the paths of a development which has hitherto been partially inhibited, and of which his/her adult life usually bears the traces.

One can consider that the human being's psycho-affective development is mobilized by the three following elements, which are those that one will find again at the heart of the therapeutic process:

- the problem of **basic security**, which is what the theory of attachment demonstrates;
- the **interactivity** and the **inter-subjectivity** of the human subject who, from the beginning of his/her life, communicates in interaction;

- the **oedipal structure**, which orients the child's desire, and then the adolescent's desire, towards aims of self-accomplishment outside his/her nuclear family.

Basic Security and the Attachment Process

Human attachment: attachment modalities

The attachment process is defined by the fact that a child, until he/she is about two and a half years old, develops an attachment relationship with the person, who is in relation with him/her in a caring and constant way (Bowlby, 1953).

The attachment system is essential for life. It comes into place in the child within the first few hours of life and is predetermined by the child's need to survive. Four types of attachment have been highlighted: **(i)** the secure attachment and three types of insecure attachment: **(ii)** anxious attachment, **(iii)** avoidant attachment, and **(iv)** disorganized attachment.

Disorganized attachment is the one that is the most preoccupying: children with this type of attachment behave as if they fear to be abandoned; they give the impression that they feel that they are in danger. They are late in their exchange capacities with adults, as well as with other children, and they are also late in their motor development. Their sleep rhythms are often disturbed. The longest sleep episode, mainly for children between 6 and 12 months old, doesn't always take place during the night (Montagner, 1988; Montagner & Stevens, 2003).

It seems that 80% of mistreated children have this kind of disorganized attachment. When they are adolescents; given this disorganized scheme, youngsters often have difficult relationships with others (Schaffer, 2007). There is no systematic causality between an insecure attachment organization and specific psychopathological difficulties. Nevertheless, the relationship between insecure attachment (not only disorganized attachment) and childhood and adolescence psychopathologies has been clearly established (Pearce & Pezzot-Pearce, 2007).

All these various attachment modalities are just different ways to obtain this attachment link, and that they constitute – for the child – a way to continue to exist and to develop, even if this attachment isn't completely satisfying or even satisfying at all. Children build attachment links with whoever is in interaction with them, even if this person is pathogenic, unstructured, or mistreating. The need for attachment is absolutely foremost and outweighs its quality. This is one of the great difficulties that we meet in our therapeutic work: the difficulty of people being attached to toxic links, which they have a great difficulty to give up – since these links, for them, have had an essential 'security function'.

In France, today, it has been estimated one child out of three doesn't have a secure attachment figure, which is quite a frightening reality. Faced with someone unknown, or with any unknown difficulty, this child remains huddled up against his/her mother, doesn't move, doesn't put him/herself in a spatial disposition in order to learn to do anything, even talk (Cyrulnik, 2012).

The attachment schemes evolve and change according to the *caregiver*'s behaviour. An attachment scheme is mobile and adapts to the variations of the quality of the attachment link. A mourning mother, or a depressed mother, may induce a particular attachment scheme, which will change when (if) she is cured of her depression. These changes take place, whatever the child's age; they can also take place in adolescence, and they also happen for the

adult, who keeps inside him/herself the imprint of his/her original attachment scheme. This is what gives its weight to the therapeutic work, which will hopefully lead to a modification of the original unsatisfactory attachment scheme.

Adult attachment and the therapeutic work

Since the 1980s, some theoretical bridges have been built between these attachment relationships for the child, and adult attachment modalities (Sroufe *et al.*, 2005; Grossmann *et al.*, 2005). The adult continues to bear inside him/herself, in his/her relation to the Other and to the world, the principles and the content of his/her early attachment style. For each of us, this attachment style continues to colour our relationships to the Other and to the world: we comprehend the world and our relationship to the Other in either a secure, or in an anxious, avoidant or disorganized way, if we keep to these four attachment schemes.

If we can develop here, in this article, what attachment really is, it is because many people who ask now for psychotherapy are people who have experienced (and often still do) problems of insecure attachment. Often, the main function of psychotherapy is to repair what has happened, or rather, what has not happened for our clients, in the quality of the attachment link during early childhood, and the consequences of this situation.

Insecure attachment processes lead children to become mainly structured in "psychotic" modes, or in "borderline" modes. Modifications that can take place in adolescence often allow for a transformation, or for reorganizations of these structural modes, but it is clear that disturbances of the early attachment relationship will orient towards a relation to the Other and to the world organized by these two structural types.

Therapeutic work can help the client to change these attachment schemes. It is thanks to the transferential relationship that, fundamentally and very slowly, a reorganization of these positions can take place. Because of what the person experiences now with the therapist, as being significantly different in the quality of the original relationship, he/she may be nourished by precisely what he/she didn't receive in childhood, which is a real psychic contact, a mindful, caring relationship now with someone available, predictable and constant.

The very young child's interactivity and inter-subjectivity

Interactivity is a primary motivation for the young human being. Since the young being is totally dependent on his/her surrounding, he/she must actively take part in the instauration of an interaction with his/her environment: he/she must express his/her needs, ensure his/her survival, develop his/her identity, and his/her capacity to think.

This early interaction feeds on a mutual adjustment of the mother and of the child to the messages which each one sends the other. Since the first hours of his/her life, the baby is active in the instauration – the action of restoring or renewing something – of this interaction, notably the baby can mimic expressions of the human face and mainly those of his/her mother [3] (Decety, 2002).

From birth on, there is an adjustment of mimics, of gestures, and bodily postures between the mother and her child: the manifestations of the one adjust precisely to the manifestations of the other. We know that the baby can differentiate from very early on his/her mother from other people, who take care or who surround him/her. These exchanges, between mother and baby, rely on what Daniel Stern

calls an emotional "affective tuning", which is very subtle, but very powerful, between the mother and her child (Stern, 1985). Through this process of fine tuning, a whole group of shared sensations and emotions are communicated almost immediately and all of the time that they are in contact.

One can see that the baby, who reacts to his/her parents' messages and actions, sending them multiple signs through which he/she recognizes the relation, gratifies them as parents and gives rise in them to the feeling of parenthood. The baby also affirms – or doesn't – its own identity. Where the attachment.

This mutual tuning process, in its subtlety and in its permanence, cannot only be seen with the naked eye: it operates on many different levels: it is – to a significant extent – unconscious on the mother's part. Daniel Stern was able to show, by deciphering recordings that he took, image by image, the delicacy of these mutual adjustments between the mother and her child: a baby's gesture corresponds to a mother's gesture; a baby's gaze to a mother's gaze; the baby's mimicry to a mother's mimicry – in a rapid and constant developing relationahip.

Gradually, through sounds, through the differences of rhythms, the child will be able to better identify what comes from him/her and what comes to him from the outside world. In the way that the baby is carried, contained, and crouched up within him/herself; and by the arms which surround him/her; in the delicacy and the respect that they put into taking care of him/her; in the breastfeeding situation, particularly, the child will be able to appreciate his/her own bodily sensations, which take meaning through his/her mother's behaviour; and through the words that she associates with what she feels is taking place for her child. In a particular way, the mother lends to her child her own thoughts; she attributes to the baby thoughts and interpretations, which will nourish them both over time – deep inside of him/her: these are what are called "proto-thoughts" about him/herself: the basis of his/her developing individuation.

The differentiation of sensations, of moments, of persons, from and by which he/she is gradually able to differentiate him/herself, produces in the child their first basic feeling of differentiation from his/her mother and a sense of self-consciousness. This differentiation occurs in the child through the perception of his/her sensorial sensations, which vary according to moments, to persons, and to the way he/she is being taken care of. This is the 'psycho-organic' unity, which the baby constitutes, and it is starting from this differentiation of sensations that self-consciousness appears. What remains in the adult of this subjectivity is linked to the body: of this subjectivity, which relies on body sensations?

Because of neurological maturation and of cortical development, the adult has become a very different being from the baby. It is nonetheless remarkable that, in therapeutic work with the adult, it is by paying close attention to their bodily sensations that one can most directly come into contact with the client's subjectivity. It is in connection with what comes out (or is expressed) from his/her body that an adult human being best perceives the power of his/her desire, with the certainty of what he/she fundamentally wishes, and with his/her competence to know what is best for him/her. It is the therapist's job to perceive this and respond to it as best as he/she can.

Together with the subjectifying effect of the differentiation of sensations, what is under play for the child in its interactivity with the Other is also crucial for the emergence of the feeling of Self. If the child's mother answers in a suitable way to her child's needs, the child will accentuate to these exchanges and this

will confirm to the child that his/her needs can be satisfied. Therefore, it is starting from the reciprocity of this relationship that the child reinforces his/her capacity to act, and also from the realization of the effects of this action. Subjectivity is also built, starting from this point.

The client in therapy often invites us unconsciously to be this good, sustaining "Other" in the relationship, in the interaction. This need for an exchange is not limited to early childhood. Adults also constantly reaffirm, in their daily life, the fact that they recognize their need to exist through these interactions and in inter-subjectivity.

Therefore, especially in therapy, the person needs to interact in a relationship, perceive the therapist's reaction to the messages that he/she sends him/her, be recognized in these interactions, and therefore be understood, respected and sustained.

For example, these types of interactions can also take place via the searching aspects of the Other's gaze. Many clients often search, as soon as they come into the office, for a visual form of contact. It is brief, it is fleeting, but it is a crucial element of the client-therapist interaction, which takes place as soon as the person's Self comes into contact with the Other, with the therapist. And that is what is also unconsciously required from us: to pass through these interactions; through inter-activity; where unconscious messages are sent – and received – for the subject's recognition.

Oedipus

Finally, the Oedipus complex is the third stage of the subject's constitution. In our view, the Oedipus complex is a scenography where the first motivations of the subject's constitution are being replayed at a different age and according to various modalities, i.e., recognition, attachment, and identity. The Oedipus complex period usually goes from 3 to 5 years old. The Oedipal situation is generally re-actualized during adolescence and then, Oedipal involvements are brought back to life, and they therefore also offer, in therapy, an opportunity to be taken up again, to be symbolized and also to find ways of resolution. We will not discuss here again what the Oedipal structure is, nor its importance in the constitution of the person's identity, nor in the person's autonomy.

As for attachment and interactivity, the problematics of the Oedipal continues to be active in what the adult is searching for, in order to contact and structure at best his/her identity, his/her power, and creativity. Also, as in any therapy, it is also the Oedipal issues which are replayed in the transferential relationship in POA.

It is on these three pillars (attachment and security processes; interactivity-inter-subjectivity; and the oedipal relationship), that the therapeutic relationship will eventually build itself, and it is around these three axes that, ultimately, may take place, in the transference: regression, reparation, and transformation processes.

Therefore, the therapeutic process puts various 'requests' into action, requests that are both conscious, but are also mainly unconscious, which are seeking to show up, to become actualized, to be recognized and repaired, in the setting of the therapeutic relationship. In therapy, one has to be in contact both with what is in movement and with what is seeking to emerge in the person.

One way for us to be in contact with the therapeutic process is to try to listen to the client's inner voice, a voice that tries to express itself, to manifest itself through what he/she says – both verbally and bodily. So, one has to try to stay in contact with their (often) hidden Self, and to reach out to it in order to meet

and greet situations that crystallize impediments to "what ought to have been". In order to bolster these emergences of their desire and of the consequential, we strive to reinforce the patient's accessibility to him/herself. One should always try to use what is emerging.

In the framework of the therapeutic process, we think the client's inner need has a major place. A major stage is to help the client to allow him/herself to open up to the issue of his/her need of the moment, in that particular situation, in order to touch the existing – and desired or desireable – subject. The client's access to his/her needs is often significantly buried at the beginning of therapy. It is often the absence of contact with his/her need which has maintained the person in their neurotic behaviours or dependencies, and that is what often motivates the entry into therapy. It is as if it were all too easy to renounce and deny one's own needs in order to satisfy what one imagines the Other person expects, or in order to confront a situation of Other's need. So, it is logical that the contact with need is very difficult at the beginning of the therapeutic process. To contact one's need, is indeed already to take some distance from the super-ego's requirements; it means to break up with often well-established contracts; it means to accept to look in the direction of one's desire; and thus to enter in a different relationship with oneself.

Putting an accent on need doesn't mean that we want to revive the child's deprivation, nor to stimulate any reactive complaint. The issue for the client is to come into contact with what he/she has missed, and with what he/she expects to experience, in order to achieve some form of an eventual reparation.

Indeed, the therapeutic process is guided by the need to repair places that were tied up by on in the person's history. This reparation can take place with the help of forms of childhood transferential involvement, which are those coming from these moments and out of these periods of his/her history.

We know unconsciously what has hindered us in our development. It is with reference to these situations that the client wishes to express him/herself, to be heard and accompanied, and it is to these places that the therapy tries to reach. It is the power of what has not been experienced in these situations which propels them on the therapeutic scene.

Nevertheless, these situations are not worked out, elaborated or experienced, at once and often not definitively. Most of the time, the approach is a progressive one, undergone while a trustful relationship is being worked out or settled with the therapist. It takes time for the client to feel that the transferential relationship offers the possibility to relive and to pass through and beyond what has seemingly to be relived and undergone. It takes time for the client's defenses to subside in relation with the evocation and with the emotional involvement of the situations concerned. It takes time to accept to come into contact with the violence, which was often present in these situations. It also takes time to accept the consequences that the sudden awareness of these situations may have for the client in his/her present life. The person's realization of these situations usually takes place in layers; at each passage, something new is elaborated, is deepened, or discovered. Therefore, the progression of the therapeutic process doesn't take place at all in a straight line, but in a helix-like fashion, each new passage bringing greater awareness, a more significant enlargement of the associative chains.

By recognizing what has been experienced, and the corresponding affects, emotions, and images, the therapeutic direction in POA endeavors to favour the person's capacity now to express and to symbolize what he/she has or

has **not** experienced. The therapeutic process can reach its aim starting from the contact with bodily and emotional experiences, and with the help of transference. So, what is this transference?

Transference

Issues of process – and of transference – are intimately intertwined. It is transference on to the psychotherapist, which allows the therapeutic process to function, since it is the instauration of this unconscious relationship that stimulates the actualization of situations which the person wishes to revisit and to repair.

From our point of view, it is not so much the realization of the type of relation put in place by transference which matters than the possibility, in and thanks to this relationship, to transform the client's experience, and to allow him/her to live other experiences, better ones, which are repairing, compared to those he/she has experienced before.

The word transference, as it is used in the field of psychoanalysis and of psychotherapy, designates the process through which a client actualizes, on the person of the therapist or on the setting of therapy, feelings, desires, relationtional ways of being, which he/she has already experienced towards important people in his/her history. Most of the time, these transferred elements are unconscious. There are as many transferences, as many qualities and varieties of transferential relationships, as there are clients.

Although at first Freud conceived transference in its oedipal aspect, we consider now (notably thanks to S. Ferenczi and to what has been called the English School of psychoanalysis with M. Balint and D. Winnicott), that in transference, sometimes very early life experiences of the person are mobilized. It is often the client's very early relationships with his/her mother or with the person who took care of him/her, which take shape in the relationship with the therapist.

Actually, transference for us concerns the three development axes we mentioned above: the security basis, inter-subjectivity, and the Oedipal mode. It is from these three phases of the foundation of development that subjectivity and independence can bloom. It is these stages that burst forth in psychotherapy, and which may be revisited, and taken care of, with the help of the transferential relationship.

Of these three moments, two occur before the appearance of language. These are development phases during which the child experiences physically what is going on: as we have seen, the child first lives thousands of bodily sensations, from which feelings appear, and then slowly thoughts, which allow progressively to perceive his/her bodily independence from his/her mother, then his/her own identity.

We see the great centrality which therapy gives to the exploration of sensations and feelings outside the realm of language. The ways in which this therapy offers to reach this area are as central. "Psycho-organic" openness is crucial. It is in this dimension that a therapeutic reparation can at best be operated.

This is the reason why the relationship is what is therapeutic. The fact that the client strives to embody again, on the therapist's person, and to change what has been deeply unsatisfying in his/her relationships, is the reason why the experience for him/her to be totally welcomed, with attention and without judgment, is an opening which he/she experiences already as deeply therapeutic.

Also, this feeling of being accompanied in the search of him/herself is a primary and essential transferential experience. A child learns to ride a bicycle because he/she is not alone to

ride a bike. To live something that is shared with the other is therapeutic: secure attachment and inter-subjectivity.

It is Freud again who has shown that to transference corresponds counter-transference. Traditionally, counter-transference is defined as the group of feelings and reactions, conscious and unconscious, produced on the psychotherapist by what is transferred by his/her client.

In the therapeutic relationship, both client and therapist are indeed totally involved, unconsciously. There isn't one who would project and the other who would be a simple mirror. The therapeutic relationship is co-created by the two persons in presence. That is what precisely makes the transferential relation rich, and what confers its transformative capacity. What matters is the vitality produced by this relation, a relation which actualizes situations, but which is at the same time mobile and evolving, changing, transforming itself and adapting according to moments of regression and to the situations of the process.

In our supervising work, we realize that what is unconsciously put into place, is often a tuning between what the therapist is able to offer and to sustain in the client's accompaniment and the client's limitation in his/her self-exploration.

Conclusion

For the client, the transferential relationship is a forbearer of discoveries, and in its process, he/she will find acceptability, presence, a warm regard, attention, relaxation, openness, constancy and acceptability.

The place given to the emergence of emotions and to their acceptance is crucial. For the therapist, being open to one's own emotions, is being open to the field of emotions in therapy. Sometimes the therapist's emotion serves as a mirror for the client, who can then become aware of the amplitude of what he/she experiences, or has experienced in the past.

Tutorage, accompaniment by the therapist to the opening to sensations, to emotions, and to feelings, opens the client to his/her interiority, to the enlargement and to the exploration, without judgment, of this interiority.

Paul Boyesen [4] has also developed the notion of "organic counter-transference". This way, he underlines that counter-transference manifests itself through organic sensations, through bodily feelings, to the perception of which one has to open oneself, since they constitute an efficient way to come into contact with what happens for the client.

Organic counter-transference manifests the capacity to bind oneself to the unconscious, somatic part of the person. That is where the unconscious desire which couldn't become embodied, the part of the self which couldn't realize itself and which waits to do so, often reveals itself.

During the session, the therapist is therefore both present to what the client manifests in his/her words, in his/her gestures, through his/her voice intonations and to emotions, but he/she is also present to what happens organically inside him/herself. A part of this bodily feeling belongs to the client, and constitutes a shared object, an object of communication which expresses through the voice of emotion and through bodily sensation, an unconscious problematic, and a suffering of the person in therapy.

The fact that we work a lot in POA on situations, or starting from situations (Tocquet, 2019), often maximizes the transforming capacities produced by the transferential relationship. At the heart of the situation mentioned, revived in the session, in the renewal of an experience which is more or less far away

from the client's present life, but which appears here and now, the therapist's attitude is crucial. He/she can change in a therapeutic way his/her client's experience in this situation, which he/she revisits and actualizes. In his/her way to sustain the client, in what he/she says, in the way he/she says it, in his/her way of being, something can be fundamentally transformed in what the client experiences in the situation at hand. The unconscious is situational. The unconscious reveals itself in situations.

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Endnotes

1. POA: Psycho-Organic Analysis
2. Studies (Lambert, 1992), on the efficiency of psychotherapies, have shown that, all techniques taken together, the elements which improve people's situations in psychotherapy are: ▪ factors which relate to the relation with the therapist, like listening, empathy, relationtional warmth, etc.: 30%; ▪ the client's expectations concerning the therapy he/she is entering into: 15%; ▪ technical

factors specific to each therapy: 15%; ■ extra-clinical factors linked to the client and to his/her environment: 40%.

3. It is only after a few minutes of extra-uterine life (8 minutes for the quickest), that a baby is able to hold out his/her tongue by imitating a person who holds out his/her tongue in front of him/her. This is extraordinary and shows the strength of the interaction, since this movement is opposite to the natural and reflexive movement at this time of life, which is a sucking movement, which attracts, on the contrary, the tongue towards the interior of his/her mouth.
4. Paul Boyesen is the founder of Psycho-Organic Analysis.

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Relational Withdrawal, Internal Criticism, Social Façade: Psychotherapy of the Schizoid Process

Richard G. Erskine

Abstract: The psychotherapy of the schizoid process is described in detail. A distinction is made between schizoid style, pattern, and disorder. The concept of psychological "splitting" of Self is discussed using metaphors of 'vital and vulnerable self', 'social self', 'sequestered self', as well as the homeostatic functions of internal criticism and shame. The importance of silence in psychotherapy and the methods of "therapeutic description" and "supported withdrawal" are explained. A detailed clinical case example demonstrates the unique form of psychotherapy that is necessary for each aspect of the self: social façade, introjections, self-criticisms, and relational withdrawal.

Key Words: schizoid, schizoid process, schizoid disorder, integrative psychotherapy, splitting, social self, psychotherapy, withdrawal, case study

"Solitude is independence.
It had been my wish
and with the years I had attained it.
It was cold. Oh, cold enough!
But it was also still, wonderfully still
and vast like the cold stillness of space
in which the stars revolve."

Hermann Hesse

In one of Maryann's early psychotherapy sessions she cried, *"I'm so confused. Sometimes I am two people or even three. I'm split inside. I can be nice to people but then I get so scared that I can't talk. I just hide. Then I beat up on myself for being so stupid. I don't know which is really me. I'm so tired of it all."* Maryann's anguish touched my heart as she struggled to speak about her "split inside". Her words were an apt portrayal of the internal struggle that we call the *Schizoid Process.*

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Schizoid is the Greek word for scissors: it means "to split". When I use the terms "Schizoid Process" or "Schizoid Syndrome", I am describing a person's tendency to withdraw from relationship, to live with an internal sense of personal isolation and self-criticism in order to avoid the potential stress of interpersonal contact. People who rely on a schizoid process to stabilize and manage internal stress are often introverted and live primarily in an internal world without much emotional contact with others, even family. They may have a well-rehearsed social presence, but the essence of who they are, their vulnerability, is hidden.

Many people who seek psychotherapy may exist somewhere on the schizoid spectrum – from *Schizoid Style*, to *Schizoid Pattern*, to *Schizoid Disorder*. Yet for many of these people their schizoid process may go unnoticed, even in their psychotherapy. The schizoid syndrome is prevalent in the lives of many psychotherapy clients, but it is often not attended to because both a schizoid style and a schizoid pattern are subtle; the clues are not obvious as they are with a schizoid disorder. After we had established a consistent working relationship, my client Maryann revealed, *"I was an expert at hiding in plain sight. I simply told my former therapist what she wanted to hear".*

Schizoid Disorder

With clients who have a clear diagnosis of schizoid disorder, their relational difficulties are often evident in the first session because they are unable to engage in interpersonal contact. Their tendency to withdraw emotionally is pervasive throughout all their relationships, as well as in their relationship with the psychotherapist. They may have a number of acquaintances, but they are usually without any meaningful relationships. People with a diagnosable schizoid disorder are more likely to avoid psychotherapy, mainly because it is too personal and intersubjective. If they do come for psychotherapy, they are reluctant to talk about their internal process and prefer to talk instead about their day-to-day activities. They often want specific solutions to a problem. Novels that portray a protagonist with a schizoid disorder provide us with insight about both their relational discombobulation and internal turmoil.

Hermann Hesse's novel, *Steppenwolf* (1927/1963) tells the story of Harry Haller, a man with a schizoid disorder, who wanders through his encounters with people like a bewildered alien, always a stranger in his community. He is prone to intellectualization; but he cannot tolerate interpersonal contact. As a result, his relational isolation and despair plague him with thoughts of suicide. In Damon Galgut's (2010) autobiographical novel, *The Protagonist*, Damon, reveals his personal anguish in a mix of first- and third-person voices, as he wanders from country to country, split between his longing to be in relationship with the various people he encounters and his desperate efforts to withdraw into his internal sanctuary. In Conrad Aiken's 1934 short story *"Silent Snow, Secret Snow"* (1960), Paul, a sensitive adolescent boy finds solace in daydreaming. He distances himself from the demands of school and family by withdrawing into a fantasy world of pure white snow – a world of silent snow that he must keep a secret. The first-person story of Paul, as well as each of the other two protagonists, provide us with a glimpse into their emotional and relational struggles. Unfortunately, none of these three stories address the qualities of relationship that the principal characters needed to heal from their internal distress.

Most psychotherapists are likely to have had some clients, who we can identify as having either a schizoid style or a schizoid pattern. The distinction between a style, a pattern, or

a disorder is in the *frequency*, *duration*, and *intensity* of their tendency to engage in relational withdrawal, to suffer from internal criticism, and to maintain superficial relationships. The intrapsychic and behavioural manifestations are the same. The term *schizoid process* refers to an entire continuum of internal and social dynamics. It is used to describe the psychological process of anyone struggling within the schizoid syndrome.

Schizoid Pattern

Evidence that a client has a *schizoid pattern* is often apparent early on in their psychotherapy, as the client tends to talk about current events while avoiding displaying any of their affect. They may talk about the people in their lives, but it is often without any emotional connection. For the first year of her therapy, Maryann used most of our therapy hours recounting – in great detail – the many novels she had read. She disregarded any inquiry that I made about her feelings or personal experiences, while continuing to tell me about the stories in her books. It took me many months to decipher a pattern in the themes of her stories – authority, betrayal, and loneliness – that were metaphors about her life.

Clients with a *schizoid pattern* may not show evidence of it in the first few sessions, but the pattern will gradually become more evident as the relational therapeutic dialogue explores the quality of interpersonal contact in the client's life. A schizoid pattern will certainly become evident if the contact with the psychotherapist becomes emotionally intense. Clients with a schizoid pattern will usually struggle to escape being emotionally involved in any intersubjective relationship.

I have found that a client's *schizoid pattern* is often first apparent through examining my own countertransference. Such clients often leave me with a sense that something important is missing between us. With such clients, my countertransference reaction is to drift towards more cognitive and behavioural interventions. I may lose my relational perspective, or I start watching the clock to see how soon the session will be over. My loss of interpersonal contact is probably being engendered both by their superficial conversation and their fear (often unconscious and unexpressed) of a meaningful interpersonal relationship. Colleagues working with similar clients report that they feel inadequate, bored, or sleepy, and/or that they have to work harder and harder trying to make something happen.

Schizoid Style

In contrast, it may be difficult to identify clients with a *schizoid style* early on in the psychotherapy. At first, they may have a compatible social presentation with a tendency to be shy, quiet, or introverted. However, when the client is stressed, or after they have been in psychotherapy for a while, the client with a schizoid style will display a tendency to withdraw from relationships, to be plagued by internal criticism, or to put on a social façade. They will talk about preferring to be alone, rather than being with people. They may find solace in reading, video games, or some solitary activity; alternatively, they may be constantly busy with many energy-consuming activities.

Clients with a *schizoid style* often come to psychotherapy saying that they are depressed. As the psychotherapy unfolds with these clients, I have found that it is necessary to attend to the intense shame that they experience – a shame that is intrinsic to their depression. They are often afraid of being criticized and rejected for what they think, or how they behave; therefore, they report constraining themselves in social situations. They may be sad about past rejections, but compensate by anticipating further denigrating comments; hence, they do not reveal any vulnerabilities. Clients with

a *schizoid style* struggle to comply with what others expect of them. They make efforts at fitting into what other people, including the psychotherapist, require. They disavow any possible anger at how they have been treated, because any protest may produce further criticism and rejection. The result of disavowing their anger and complying with others' expectations is their conviction that "there is something is wrong with me".

In my practice of psychotherapy, I have found that it is necessary to provide sufficient attention (often repeated over many sessions) to five focal points that I consider essential in the therapeutic resolution of shame (Erskine, 1994; 1995). I will briefly spotlight them here. Shame is usually composed of:

- hurt in not being accepted for ***who I am***: i.e., *"My worth as a human being is of less value"*;
- fear of rejection for ***how I am***: i.e., *"My behaviour means I'm not acceptable as I am"*;
- disavowal of anger at not being accepted ***as I am***: i.e., *"I'll criticize myself so that you can never criticize me"*.
- compliance with how **others define me**: i.e., *"I will be what you say I am"*; and,
- a belief that **"something is wrong with me"**: i.e., *"I have noting useful to say"*.

Schizoid Process

The term *schizoid process* depicts a "splitting" of the Self into various entities. The concept of "splitting" is borrowed from the early psychoanalytic literature and is used as a metaphor to explain our client's experience that their sense of Self is internally divided into diverse parts. Ronald Fairbairn (1954) used the term "splitting" to portray an archaic, self-protective polarization of a sense of self that is the result of overwhelming and conflicting affects (Rubens, 1996). R.D. Laing (1960) also used this concept in his book title, *The Divided Self*. Although the concept of splitting is not theoretically consistent with a physiological and relational perspective of psychotherapy, it serves as a useful metaphor in describing the client's internal sense of being segmented into various selves.

Therefore, I use the concept of splitting as a metaphor to describe how a child will struggle in their attempt to preserve their vitality and protect their vulnerability by dissecting their natural, whole Self into several manageable parts. My clients seldom use terms like "splitting" or "schizoid"; they simply say, *"I have different parts"*, or *"I'm split inside"*. It is my conviction that each "part" requires its unique form of psychotherapy. [1]

However, when we use the term splitting, we are describing a different dynamic than dissociation. As clients describe it, dissociation is a sense of "me" and "not-me", whereas splitting has a sense of "me" and "me" and "also me". Dissociation is often the result of physical and/or sexual trauma, persistent abuse, and a disorganized family environment. The splitting of a sense of Self seems to occur when children have parents who are consistently experienced as simultaneously being *neglectful* and *controlling*. The result may be an *implicit fear of invasion*. Maryann described her mother as: *"... a bee hovering around a flower, helping to pollinate, but always buzzing, pestering ... and with a potential stinger. So, I learned to shut her out. I told her nothing. I wouldn't accept her pestering me and I didn't accept her helping me. I learned to live on my own."*

Clients, who rely on a schizoid process to manage their affect, report that – in their childhood – significant caretakers were constantly misinterpreting their emotional expressions while – at the same time – controlling their sense of identity. In general, they report that their parents:

- constantly mis-attuned to their affect and rhythm;
- were overprotective and authoritative;
- were critical of their behaviour and their sense of "*who I am*"; and,
- failed to provide the tenderness and security necessary to heal from these traumatic relational ruptures.

As a result, they are left with an implicit and intense fear of invasion. In response, they learned to 'split off' any affective connection with their caretakers; they distanced themselves, as a way to manage the confusing relationship; and they removed themselves from the intensity of this fear by 'splitting off' their own sense of vulnerability, intimacy, and contact with self.

After a few years of psychotherapy, Maryann was able to summarize her schizoid process in her own words: *"Even before I went to school, my natural need to depend on my mother was continually met with a lot of fussing and smothering. She continually misinterpreted any emotions that I had. She was always controlling and invasive".* Maryann went on to describe how, as a very young child, she sensed that *"to be vulnerable was risky".* She told several stories about how she developed patterns of relationship marked by a social façade and the absence of emotional expression.

When "splitting" is used as an attempt to self-stabilize, the vital core of the personality is withdrawn from the self that lives in the external word. The driving force is fear (Guntrip, 1961). Harry Guntrip, in a significant article about the schizoid process, says that a child: *"is capable of **fear** so intense that it can amount to fear of death in the absolute sense of annihilation"* (Guntrip, cited in Hazel, 1994, p. 161). Because of repeated criticism, control, and relational conflicts, a child under such stress may deny their need for security-in-relationship. Security may then be pseudo-accomplished through fantasies of being in a safe hiding place: a cave, wardrobe, closet, or womb.

People with a schizoid process may engage in *relational withdrawal*, a blankness or fantasy that does not involve real people. These clients described how they created a sense of security for themselves – a pseudo-security that requires no interpersonal relationship. They talk about their preoccupation in a world of constant work projects, excessive reading, video games, or TV. Some clients have described how they imagine being alone in their safe hiding place where their affect is diminished, *"All is quiet"*, *"... there are no conflicts"*, *"... the rhythm of life is slowed down"*, and, *"... the conflicts with my mother are forgotten".* Marye O'Reilly-Knapp writes about her client's relational withdrawal:

> *"In the withdrawn and hidden places there is only existence, with no true sense of self, and no sense of self with another. The person remains uninvolved, unintegrated, and lives in quiet desperation."* (2001, p. 48)

It seems to me that many clients, struggling with their schizoid process, bring into their relationships with their psychotherapist a twin desperation: the desperate fear that they will be invaded once again, and the desperation of profound loneliness. Donald Winnicott (1988) summarized his patient's schizoid process as an attempt to regain psychological stability by creating *"isolation in quiet".* Guntrip summarizes the schizoid dilemma with:

> *"They are caught in a conflict between equally strong needs for and fears of close good personal contacts, and in practice often find themselves alternatively driven into a relationship by their needs and then driven out again by their fears."* [italics in the original] (Hazel, 1994, p. 164)

Our clients' relational withdrawal may be stimulated by several different factors:

- **When there is external criticism and/or aggression.** For example, one of my clients hides in her bed after her husband criticizes or shouts at her. She stabilizes herself by imagining that she is in her baby-crib with padded sides all around her.
- **When the pressure of internal criticism becomes oppressive.** Another client struggling with his schizoid process suffered from constantly saying to himself, *"I'm worthless"* and *"I don't deserve anything"*. In response, he felt a constant urge to hide from people.
- **When the psychotherapy relationship is perceived as consistently providing protection; when there is sufficient security to be able reveal their secret place:** *This withdrawal is for the purpose of relational repair*. The client's therapeutic withdrawal is motivated by hope for healing contact but at the same time this relational withdrawal is laden with fear. There is a flickering sense of hope that the psychotherapist will understand their desperation, provide safety, and be attuned to their rhythm and affect. Simultaneously, they are afraid of possible criticism and invasion, a speed of interpersonal interaction that they cannot manage, and a demand that they be in a close relationship. Hidden beneath all of this is a deep fear of abandonment, so they are often the first to disrupt the therapeutic relationship.

Whenever I made inquiries about Maryann's feelings, I noticed that she would look toward the window. At first, I asked about what had occurred just before she averted her eyes, but she was unable to answer. My attempts to get any answer were followed by her looking at the floor. She shrugged her shoulders and offered what seemed to be a superficial answer. Sometimes, she would tell me the details about a book she had read. I was left not knowing what was happening in her internal world.

Many clients who engage in a schizoid process will not reveal their relational withdrawal, or talk about their secret hiding place, especially if the psychotherapist lacks attunement to their rhythm and affect, or if the psychotherapist is focused on interpretations, behaviour change, or uses confrontation. With such therapeutic interventions, the client will just turn away and will subtly withdraw. The child psychoanalyst, Selma Fraiburg (1982/1983) identified how infants will "turn away" from interpersonal contact after they have experienced relational disruptions with their significant caretakers. The "turning away" from a parent, who is invasive or controlling, when used repeatedly in early life, may become a pattern used in other significant relationships. Clients who rely on a schizoid process will internally "turn away" if there is a hint of control or invasion.

I eventually realized that Maryann's "turning away" was a clear indication that she experienced some uncomfortable disruption between us whenever I made a phenomenological inquiry. Over time, she was able to tell me that my inquiries, such as: *"What are you feeling now?"* or, *"What do you remember about…?"* were understood by her to mean: *"You are wrong for feeling what you are feeling"* or, *"You always exaggerate"*. She could not hear the caring and interest in my inquiry; she only imagined ridicule. Hence, she turned away or talked about one of the books she read.

Clients, who use a schizoid process to self-stabilize, often come into psychotherapy because they feel depressed. They may appear to be adaptive, with socially appropriate behaviour, but internally they have a vulnerable, frightened Self that is deeply hidden from interpersonal contact.

The Vital and Vulnerable Self

They are secretly very lonely. Their relational needs force them to come out of hiding in order to make some (usually superficial) contact with people. Maryann's description of herself provides a good example: she was active in two charities; she organized fundraising social events for hundreds of people; she was an active board member in her professional association; and she attended many dinner parties – but she was often *"secretly depressed"*. She said, *"I prefer to just be left alone to read, but then I make all these social obligations that must get done"*.

Some clients who use a schizoid process have a social façade wherein their vulnerability is secret. Their *vital & vulnerable self* is withdrawn and in hiding and they have a *social self* that is well rehearsed. Some clients may be able to engage in business and social activities effortlessly because they are able to present themselves with a "social mask". This social façade helps them navigate a variety of interpersonal situations – but on only a superficial level. Harry Guntrip (1968) referred to this duality as the "schizoid compromise", where the person lives half in the external world and half in a secret hidden world. Clients who have a schizoid process are perplexing to many therapists because they may:

- have difficulty talking about needs, physiological sensation, and affect;
- forget what was discussed in previous sessions;
- be self-critical of any vulnerability, emotions, or the idea that they may have relational needs;
- be overwhelmed by shame;
- be frightened by phenomenological inquiry;
- fear dependence on the psychotherapist;
- have no memory of the interpersonal contact between self and the psychotherapist.

This list of symptoms may apply to many clients, who would not be diagnosed with either a schizoid *pattern* or *disorder*, but who may rely periodically on a schizoid *style* especially when they are under stress.

The 1st Split: The Social Self

Ronald Fairbairn (1954) described how children, who have their affect and relational needs responded to with attunement and vitality, will develop a "Whole Self". He used the term "libidinal ego" to describe the child's liveliness. This is what John Bowlby (1988) called a "Secure Self". This "Whole Self" is *'vital'* and *'vulnerable'*, sensitive to both over- and under-stimulation, with a desire to explore, learn, and grow.

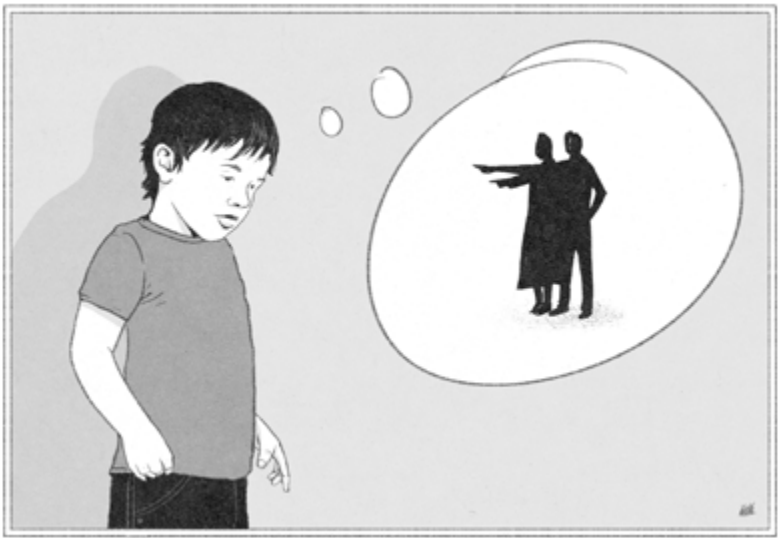
As I mentioned at the beginning, Fairbairn used the metaphor of "splitting" to describe his clients' internal struggles. "Splitting" is not real. People don't actually split their Self, but they may suffer with internal criticism and shame; they may actively keep significant feelings, needs, and internal dynamics a secret. The concept of "splitting" is a metaphor and, as a metaphor, it is a useful way for us to think about our clients and what is therapeutically needed in their relationship with us. In the section that follows, I will illustrate four types of "splitting" and share with you some of what I know about working with each aspect of the Self.

"Splitting": A Useful Metaphor

First Split

With repeated physical, rhythmic, and affect mis-attunements, developmentally unreasonable demands, and/or unrelenting criticism, a split may occur in the child's sense of Self. In response, a *'Social Self'* may be formed that hides the *'Vital* and *Vulnerable Self'*. This first split is an attempt to be accepted, validated, and attached to caregivers. The child learns to adapt to what is expected because any form of self-expression or protest could be dangerous. Without the intellectual development to comprehend the ramifications, the child may conclude, *"I will be what you want me to be."*

Donald Winnicott refers to this split as *"organization towards invulnerability"* (1992, p. 198), the creation of a *'Social Self'*. It is as though the child is deciding, *"If I am compliant, I am less likely to get hurt"*. Selma Fraiberg (1982/1983) described how very young children, even prior to the acquisition of language, learn to transform affect and behaviour in order to be ac-



The 2nd Split: Introjected Others

cepted, validated, and loved. Anger, fear, or unacceptable behaviour may be split-off and replaced with a social mask of cooperation. This newly created '*Social Self*' maintains superficial relationships with people while the '*Vital & Vulnerable Self*' is hidden behind a social mask. Donald Winnicott called this 'Social Self' a "false self" (1960), while Eric Berne called it an "adapted child" (1961).

My client, Maryann, described this first split articulately:

> *"I know I am segmented into parts because I'm not authentic with people. I am always acting smart and helpful, even when I don't know what is happening. I am always feeling pressured when I am with people. I work hard to please them but, at the same time, I long to be alone. But when I am alone, I'm either nervous or I just want to sleep. I don't know what I really want."*

While some pseudo-security is achieved by displaying a Social Self, the child remains anxiously attached, because their emotional stability is always threatened. Sometimes, the 'Vital & Vulnerable Self's' natural feelings, desires, and needs leak through the split and are expressed. The child then runs the risk of disapproval, rejection, and punishment. The fear of punishment leads to a second split.

Second Split

As a way to maintain some attachment to their primary caretakers, the child will introject the thoughts, feelings, and behaviours of their significant others. Introjection is a self-stabilizing, unconscious identification with a significant caretaker that occurs in the absence of need-fulfilling contact (Erskine, 2003). Introjection functions to provide a false sense of attachment when the secure attachment is threatened.

With introjection, vital aspects of the Self are replaced with characteristics of the significant Other person. The introjected thoughts, feelings, and behaviours dominate the child's sense of Self. Vitality is lost and the vulnerable child refrains from full self-expression. Unfortunately, since the parents have become internalized, these introjected Others follow the child wherever they go. Instead of vitality, the child feels shame and disappointment.

The 3rd Split: Internal Saboteur

Maryann said, *"I cannot remember my mother's actual words, but I just know that she wanted me to be perfect. She was always correcting the way I talked or looked so that her family and friends would think that she was a good mother. Right now, I can feel a pressure in my head to be social and happy looking the way mother always wanted me to appear".*

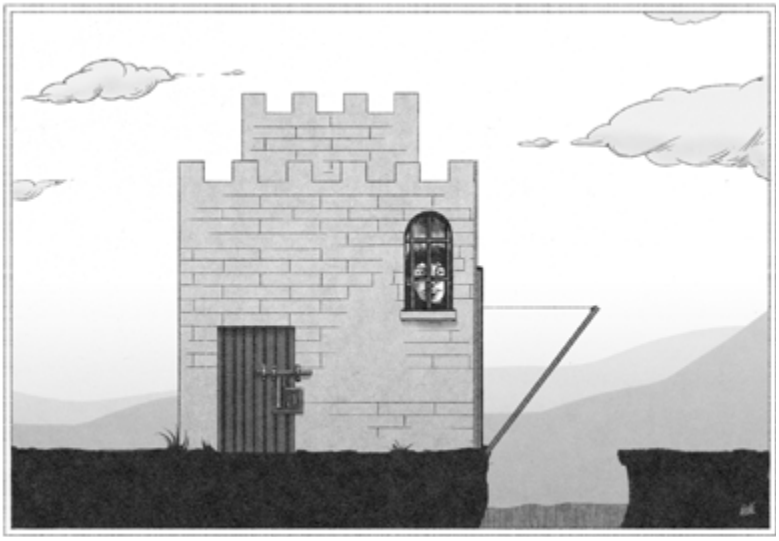
Third Split

As children mature, they become increasingly aware of the introjected attitudes of their parents. In order to stay attached to the parents, a child will deny the effects of the parents' criticisms and controls. As a self-protective strategy, they learn to criticize themselves. This self-criticism may be more demanding, intense, and continuous than the original criticism. With some clients, we refer to this self-critical part as an '*Internal Strategist*'. With other clients, we call this the '*Saboteur*' because its purpose is to be more powerful than the introjected voices in order to maintain an illusion of attachment and an identity separate from the introjected criticism.

Maryann had volunteered – for a third time – to organize a large function to raise money for a charity. For the next several weeks, she was plagued by a loud internal voice that repeatedly said, *"I won't do it right"*; *"I'll look foolish"*; *"I can't produce what they need"*; *"Stop being so tired and just push through it"*. She described the harsh bitter tone as her own internal voice.

As we examined what she felt and remembered, she realized that these were the same admonishments that she *"... had lived with all the time in high school and at university. They are what made me get good grades, trying to be perfect".*

This self-created 'Saboteur' is clever in that it takes pre-emptive control by criticizing the 'Vital & Vulnerable Self'. The person becomes their own oppressor – the 'Vital & Vulnerable Self' is frightened and goes into hiding; self-expression is perceived to be dangerous. Self-created criticism functions as both a deflection from awareness of the introjections and also as a way to have some control over difficult interpersonal situations. One client described their self-criticism as a *"ghost that*



The 4th Split: The Sequestered Self

follows me everywhere", while another called it a *"monster that hangs over me all the time"*.

The internal criticizer is controlling and despising of one's own relational needs, desires, and feelings. The constant self-criticism ensures that the person does not receive, seek, or even become aware of needs and feelings, except for the shame of having feelings and needs. It protects the 'Vital & Vulnerable Self' from the criticisms of others but it destroys the very vitality it is trying to protect. Both the 'Saboteur' and the 'Social Self' function to anticipate – and avoid – real dangers of interpersonal conflict by inflicting an even more severe criticism on themselves.

During the second year of her psychotherapy, Maryann revealed some of her internal criticisms: *"I'm not worth anything"*; *"I don't dare make mistakes"*; *"No one likes a depressive like me"*. Maryann often concluded her social activity stories with, *"I'm just not good enough"*. These self-criticisms preceded and superseded any possible criticism from other people because Maryann strategically neutralizes any potential disapproval before it is ever made. However, rather than protecting her, each of these self-inflected criticisms increased her sense of *"... feeling pressured when I am with people"*.

Fourth Split

Under the intense pressures of either external criticism, introjected criticism, or the oppression of the 'Internal Saboteur', there may be a fourth split in the person's sense of self. They may withdraw to a 'Sequestered Self', where their vitality and vulnerability is completely disconnected from all human contact in a search for peace and quiet. Marye O'Reilly-Knapp (2001) calls this fourth split, the "encapsulated self", where the person withdraws into their internal world because they are convinced that there is no security-in-relationship. This withdrawal is like living in a secret and protective closet, cave, or castle where the client can hide from demanding relationships.

As our therapy relationship progressed, Maryann put into words her strong urge to withdraw from any human contact. *"I hate the*

pressures I have always lived with. I don't want to be social. I just want to find a quiet place. Often I go to a toilet and sit there for 10 or 15 minutes just to escape people." On another day, she added, *"Even though I am lonely I never want to be in relationship with a partner. I don't want them messing with my life. I just want to be left alone to read my books. Books never invade me."*

Considerations for Psychotherapy

A unique form of psychotherapy is needed for the Self that emerges from each split. Some clients will require that we attend to the 'Social Self' first. Other clients will require relief from introjected messages, attitudes, or criticisms of significant others before we can proceed. Usually, later in the psychotherapy, it will be necessary to address the functions of the self-created criticisms, and most will require careful attention to the 'Sequestered Self'. The various methods are not sequential. The focus of the psychotherapy may flow from one aspect to another and then back again. Some clients may be burdened by internal criticism and have a compulsion to maintain a social façade, while others will be secretly hiding from interpersonal involvements. Adjusting the psychotherapy for each individual – and their unique split of the Self – requires that we think and work multidimensionally.

Each part of the Self has its unique pattern of relational attachment. In creating an effective in-depth psychotherapy, it is essential that the psychotherapist respond to the style of relational attachment unique to each part. The 'Vital & Vulnerable Self' reflects securely attached relationships where parents were predictably responsive to the child's various needs. As a result, the person is interpersonally contactful and excited about exploring and learning. Even secure individuals need acknowledgement, validation, and ongoing responsiveness to their emerging relational needs.

Working with the first split: The 'Social Self' is relationally attached by *hope* and *anxiety*, because significant caretakers were *unpredictably responsive*. Out of hope and anxiety, they cling to dysfunctional relationships; they will adapt to the other at any cost. When our therapeutic work is focused on the 'Social Self', I find myself wanting to help the client acknowledge the various ways that they have adapted. I try to validate the significance of their compliance. I help the client explore the advantages of a 'Social Self', such as: maintaining attachment; less possibility for humiliation; less punishment; or, achieving some comforting attention. I also help the client recognize the various disadvantages of a 'Social Self', such as: loss of joy; loss of vitality; emotional numbness; or, loss of physical sensations.

I strive to help the client discover the vital aspects of the self that have been lost such as joy, anger, excitement, exploration, and their uniqueness. Much of our therapy time may be devoted to helping the client become more aware of their body sensations, becoming sensitive to their various affects, and validating the importance of vulnerability. This includes helping the client discover their relational needs – both the needs of childhood, as well as today's relational needs.

When working with the split between the 'Vital & Vulnerable Self' and the 'Social Self', I often use the Gestalt Therapy "empty chair" method to enable their 'Vital & Vulnerable Self' to express their body sensations, affects, and the homeostatic functions of splitting. I want to support the client's natural protests and to facilitate him or her in identifying and expressing their physical and relational needs.

I might also use the "two-chair" method to externalize and resolve the intrapsychic conflict between the 'Social Self' and the 'Vital &

Vulnerable Self'. It may be necessary for the client to physically express retroflected feeling and to actively protest to the introjected Other(s) by defining one's Self. Any of the methods that invite clients into interpersonal contact are effective in working with this first split. The Gestalt Therapy methods of the "empty chair" and "two-chair" techniques are designed to clarify and resolve the intrapsychic conflict between a person's natural desires and the introjected attitudes of significant others (Perls, 1969, 1973; Perls & Baumgardner, 1975).

The 'Vital & Vulnerable Self' is often confused, like a frightened child. Many of my clients learned to be compliant at several developmental stages. I find it necessary to talk to the child in my client about what they might have needed from an attuned parent. I want them to become aware of how they managed the criticisms and demands placed upon them. I aim to provide the quality of relationship that is protective of the client's exploration of change. I provide permission to be authentic, self-expressive, and intimate. However, I always want to assess the level of internal punishment before giving encouragement to change.

When working with the split between the 'Vital & Vulnerable Self' and the 'Social Self', I tend to encourage the client to express their relational need for self-definition and their need to make an impact. The expression of these vital needs can occur relationally between the client and a receptive psychotherapist, or to an imagined Other by using the "empty chair" method.

After several sessions in which I talked with Maryann about the absence of any joy in her life, her physical and emotional numbness, and her constant urge to either read or sleep, we contracted to do some two-chair work. I asked her to imagine her 'Social Self' in one chair and her 'Vital & Vulnerable Self' in the other. My role was to function like a cinema director, to suggest when she might change positions. We began with the 'Social Self' boasting about having many friends and activities, how she received lots of attention and praise from acquaintances, and admonishing the other part of her for *"hiding from people"*. Then, I suggested that she change chairs, so as to give her 'Vital & Vulnerable Self' a chance to express what she was holding inside.

The 'Vulnerable Self' talked about how burdened she felt with all the social activity, with *"putting on a good face"*. As I encouraged her to put her inner sensations into words, she detailed her loss of hope and desire and then added, *"I have no pleasure in life because you are always playing a role"*. At this point, I asked her to change chairs. We continued the dialogue, back and forth, from one chair to another, for another 15 minutes, until the 'Vital & Vulnerable Self' became a strong voice and proclaimed that, *"I have the right to be me. If I want to be social I will do it and if I want to be alone I will be alone. … And, I appreciate how you can adapt to any situation; you are successful with people. I don't want to lose that skill but I also need to be alone, the freedom to be me."* With this two-chair dialogue we were facilitating an integration of these two divergent parts of herself.

Working with the second split: In the second split, the child has unconsciously identified with some significant Others in order to disavow their needs and feelings and to, importantly, maintain a semblance of a relationship. Although they struggle to maintain attachment, their pattern is *Avoidant* because significant caretakers were *predictably unresponsive*. They are attached via *neglect* and *aggression* – two sentiments that are often turned against the 'Vital & Vulnerable Self'.

When the internal conflict is between the 'Introjected Other' and the 'Social Self', I use phenomenological inquiry to identify how the

client complied with messages and demands. I use historical inquiry to identify any criticism and control that may have been a part of their life – and I encourage them to talk about their fears, the lost opportunities, or punishments that they may have received for being authentic.

Sometimes, I might use a two-chair dialogue to externalize the introjected criticism and to facilitate the person becoming aware of the importance of a 'Social Self', or I may use myself as an *interposition* between the introjected Other and my client's 'Social Self' or 'Vital & Vulnerable Self'. I may engage my client in actual psychotherapy with the introjected Other (see Erskine, 2015, Chapters 16 & 17, for a detailed description of these methods).

In the second year of Maryann's psychotherapy, once she seemed reasonably secure with me, I asked Maryann to imagine her mother sitting in a chair across from the two of us. I talked with Maryann about how I would support her, both as a child and as an adult. I encouraged her to tell her mother what she had never said aloud. At first, Maryann was hesitant in talking to the image of her mother. After a few fearful interruptions, she was able to say aloud, *"You have always controlled me. I was never allowed to be me"*. I coaxed her to say it with the full intensity that she felt inside and she exploded with, *"I want to be me. I want to make my own mistakes. I want to be me. But being me was not good enough for you."* She stood up and shook her finger at the mother she imagined in the second chair, *"You are the one that's imperfect. I'm never good enough for you ... but it is you who has a problem. You could never appreciate me."*

Working with the third split: The self-created criticism of the Saboteur begins as a three-part strategy:

- to deny the emotional impact of the actual criticism from others;
- to remain unaware of the internal influence of the introjected criticism;
- to ensure that the 'Vital & Vulnerable Self' remains protected, out of sight, and unexpressed.

The relational attachment pattern of the 'Saboteur' is disdainful. They undervalue relationships and inhibit sadness, fear, and intimacy while being full of rage. They have an implicit fear of vulnerability.

With several clients, I have discovered that their internal criticism is a secret, as though they are ashamed of it. The constant internal criticism may be traumatic because there has been no reparative relationship that served to neutralize the toxicity of the criticism. I invite the client to say the criticism out loud, so that I can hear and feel the impact of it.

Then, I encourage them to amplify the volume and intensity of the internal criticism, so as to externalize what has been internal. I want the client to be able to distinguish the difference between the self-created 'Saboteur' and the 'Introjected Voice'. I may engage the 'Saboteur' in a dialogue about the origin and purpose of the criticism. The tendency for self-created criticism often begins in early adolescence, as a strategy to protect one's Self from Others' criticism, control, and rejection. I focus our therapeutic dialogue on the original purpose of the criticism and how that purpose no longer applies in the client's life today.

In the first year and a half of her psychotherapy, Maryann would allude to *"an inner voice that controls all that I do"*. She was reluctant to give me any details about what the voice said. One day she uttered, *"The voice always pressures me. I just want to escape into a good book"*. She then realized that she had two different sensations: the first was that she was ashamed of having the voice, and second, that she felt overwhelming shame with the criti-

cisms that the voice was saying. She was confused: *"Sometimes I think the voice is my own and sometimes it's similar to my mother's harangues."*

Over the next several weeks, I devoted some time in each session to give Maryann an opportunity to express internal criticisms out loud so that both she and I could hear them in their full intensity. Eventually, she was able to voice several of her internal condemnations: *"I'm a fake"*; *"I didn't do it good enough"*; *"I'll never make it"*; *"I look so awful that everyone will laugh at me"*.

As we explored the function of each of these self-created criticisms, Maryann became aware that she had created the voice, *"to beat my mother at her own game! If I criticize myself, I don't have to remember her criticisms"*. This led to her having a series of memories – memories that she had not previously been conscious of. *"My mother was constantly invasive. I had to find a way to drown out her controlling voice."* In a later session, she discovered that a second function of her self-created criticism was: *"... to make me do what I didn't want to do. All through my life these internal criticisms pushed me to stay awake and study, to work hard, to put on a good face for people. The criticisms have helped me to be successful at work and in all my social activities because I am always working hard to adapt to the critics. I hate my self-criticisms yet I am afraid that if I give them up, I'll never be good enough. This is a shitty situation. I want to be free to be me."*

Working with the fourth split: The 'Sequestered Self' is hiding, longing for security, quiet, and escape from painful interpersonal relationships. The attachment pattern of the 'Sequestered Self' is *isolated*. Relational withdrawal is used to manage their intense affect and to escape from either internal criticism or possible external criticisms. Psychotherapeutic methods that are effective for other parts of the Self may not be effective for the 'Sequestered Self'. The client withdrawing from interpersonal contact requires a unique form of psychotherapy to help heal them from the hidden wounds of cumulative relational failures. For a detailed case presentation on working sensitively with a client's 'Sequestered Self', see the article entitled: "Relational Withdrawal, Attunement to Silence: Psychotherapy of the Schizoid Process" (Erskine, 2020).

When working with the 'Sequestered Self', I focus on providing security within our therapeutic relationship. Once the client has some sense of security in our relationship, I proceed with helping the client to feel their physical sensations, affects, and memories. This is much deeper awareness work, often quiet and less conversational than when working with the loss of sensations in the first split. Although they do not trust, they need a psychotherapist who is reliable, consistent, and dependable. In order to facilitate the client's internal sense of security, I sometimes invite them to withdraw while they are in our therapy sessions, to go to their "quiet place".

I recommend that they close their eyes and take a few minutes to feel the safety of being in their private place. I speak to them slowly and reassuringly with, *"I'm staying right here"* and *"I'm listening to you, even when you are silent"*. I don't expect a response. I'm patient and provide time for the client to make internal contact with their body sensations, feelings, and memories – without talking. While they are in their quiet, private place, I may speak to them in short validating sentences:

- *"It is important to have a quiet place."*
- *"It is necessary to feel safe inside."*
- *"There is no need to hurry."*
- *"I am right here watching over you"*.

I have learned that, when a client is in their sequestered place, the best thing I can probably

do is relax and not try to make something happen. I often do some deep, calming breathing myself, while staying focused on the client's non-verbal experience. I create the time and place for them to feel both the security of their "quiet place" and my quiet, non-demanding presence.

When the client has a tendency to withdraw from interpersonal contact, phenomenological inquiry – effective with many other types of clients – may not be appropriate. They may become silent or provide only superficial responses because they have experienced inquiry as an invasion, or as a demand for the "correct answer". Instead of using phenomenological and historical inquiry, *therapeutic description* may be more effective.

Therapeutic description provides the client with validation of their often unspoken emotional and physical experiences. Therapeutic description is based on attunement to the client's rhythm, affect, archaic and current relational needs, and an understanding of their cognitive process. Therapeutic description provides a vocabulary for previously unspoken experiences to be acknowledged and eventually talked about.

It also facilitates an interpersonal connectedness between client and psychotherapist by providing the client with a sense that, *"my therapist knows my internal experience, my fear of relationship, the safety in silence, the importance of hiding, and the depth of my loneliness".*

Therapeutic description is not the same as explanations or interpretations that may be given to other clients to enhance their cognitive understanding of their psychological dynamics. It is about attuning our self to our client's non-verbalized sensations and experiences and helping the person form a language to talk about their physical and emotional sensations.

The effective use of therapeutic description requires that we use a tentative voice, not a voice of certainty, and pay very close attention to the client's physiological reactions of acknowledgement, disagreement, or nothing. Here are a few examples of translating phenomenological inquiry into therapeutic description. Rather than asking:

- *"Why are you quiet?"*, a therapeutic description such as, *"It must be important to be quiet"*, may be much easier for the client to accept.
- *"What are you feeling?"*, it may be more effective to simply state a description, *"It must be difficult to find words to describe what you are feeling".*
- *"What is happening in your body?"*, it may be more contactful with clients who tend to use relational withdrawal to say something like, *"Your body must be tense holding all those feeling inside all the time"* or *"Being in a safe hiding place seems so necessary".*

Throughout Maryann's time in psychotherapy there were many times when I witnessed her momentary withdrawal. I would inquire, *"Where did you go?".* In response, she would immediately answer, *"I was just thinking".* If I inquired further, she would give me a deflective answer about something happening in her social life, or about what she had just read. I sensed that she was not "thinking" but that she was retreating to some internal place.

If I inquired with, *"What just happened? You seemed to go away"*, her face would form a scowl and she would turn away in silence. I surmised that she heard each inquiry as an accusation that she was doing something wrong. I began making comments instead of an inquiry: for example, *"My questions must seem invasive"*; she responded by giving a *"Yes"* nod of her head. Whenever I would notice a brief re-

treat to her internal place, I stopped inquiring. Instead, I described what I imagined her experience to be, "*It must seem necessary to go into a private, quiet place".* She again nodded a "*Yes".*

When I would see her withdrawing, I began making therapeutic descriptions such as, "*It is important to have a safe place to rest"*, "*It must be overwhelming listening to people"*, or, *"I'm right here, even when you are quiet".* My comments attempted to describe her internal process and what she might need; they were not as invasive as my questions, and she remained free to stay in her safe internal place.

Maryann began withdrawing more frequently in our sessions. I would like to think that her willingness to withdraw to her place of safety while being in my presence was now possible because of the non-judgemental, non-criticizing perspective that I brought to our psychotherapy relationship during the previous years. She now seemed to feel safe enough in our therapeutic relationship to allow me to witness her retreat to her "hiding place". People struggling with a schizoid process will withdraw when there is a threat of invasion, but they often try to keep their withdrawal a secret. Yet, when they feel secure in a therapeutic relationship, they will sometimes withdraw in search of healing – a healing that occurs through the psychotherapist's sustained attunement to the client's affect and rhythm.

So, I increasingly sat in silence and relaxed with my yoga breathing. I watched her intensely for any clues as to what she was experiencing and I periodically made comments like: "*There is no rush. Take your time to be quiet"*; "*Having a safe place is so important"*; or, "*In a private place, no one can criticize or control".* I watched her head and shoulders for the little nods of agreement; these were my guide to continue with my therapeutic descriptions. Sometimes, there would be no nod. Then I would patiently wait in silence and, some minutes later, I made a similar therapeutic description that I hope would reflect her inner experience.

In each session, I would reserve time long before the end of the session for us to discuss what was occurring in the psychotherapy process. She repeatedly informed me that my quiet, patient way of being with her was "*a salve, a soothing ointment".* Following another session, she said, "*I had to invent a quiet place. Growing up, I had no safe place in which to go. My mother was always hovering over me. But you are just there. You are not demanding anything of me. You are not actually with me, but you are out there, safe. Like you are watching over my welfare".*

With this kind of therapeutically supported withdrawal, Maryann began having vivid memories; she would withdraw into her quiet place for about ten minutes, and then she would suddenly have a memory. As we continued the supported withdrawal, her internal images were of an increasingly younger age. Her memories were not explicit, rather they were composed of impressions, body sensations, and procedural reactions. Through therapeutic implications, we were able to compose a story about her deep sense of loneliness.

In my experience as a psychotherapist, there are many errors that I have made while working with several clients who use a schizoid process to stabilize their affect. I have been fortunate to have clients who have served as my teachers, who have helped me understand and appreciate the whole 'Schizoid Process' and – in particular – what they need in a healing relationship. Their honesty and ways of being in our sessions have periodically exposed dimensions of my countertransference that were not obvious with other types of clients, such as, my desire to achieve a specific outcome and my urge to 'do' the psychotherapy quickly. With such an internal urge, it is

almost impossible to attune to the clients' sequestered rhythms and affects.

I have learned that it takes patience and long moments of silence to reach the client's 'Sequestered Self', and much longer to provide a consistently dependable healing relationship (Erskine, 2021). It is essential that we psychotherapists foster a sensitivity to the client's never-spoken, emotion-filled, internal story; adjust our psychotherapeutic involvement to the rhythms of a frightened child; and, attune to the clients' deep sense of fear and loneliness.

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Endnotes

1. **Editor's Note:** This has similarities with treatment of 'Sybil' in the 1973 book by Flora Rheta Schreiber and also in "Shatter: The True Story of Katy Roth's Eight Personalities" by Nancy Clark in 1986. However, the clients featured in both of these book were fragmented into different personalities as a result of traumatic dissociation.

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The Success of Psychotherapeutic Interventions in Enhancing Welfare in Adult U.S. Cancer Patients

Ruby Dagher, Carine Kabbara & Ibrahim El Tannir

Abstract: This paper reviews literature on the impact psychological interventions can have on adult cancer patients in the United States, and the extent to which they can improve mental and physical wellbeing. Evidence from multiple articles is included and carefully analysed to assess the efficacy of these interventions that include music and art therapy, cognitive behavioural therapy, hypnotherapy, and positive psychotherapy, among others. Although the authors use different methods for approaching their studies, either though questionnaires, surveys, or scales, results are shown to be consistent with the research question at hand. The study concluded that providing these psychotherapies to cancer patients causes an improvement in multiple symptoms, including better mental health, reduced pain sensations, and boosted feelings of self-worth and confidence. The secondary effects include stronger immune system responses as well as improved blood pressure and circulation. Further studies are needed to encourage hospitals to increasingly employ psychotherapies for their cancer patients.

Key Words: psychological interventions, cancer treatment, non-pharmacological interventions, mental health, pain management

Cancer, one of the most feared diseases in the world, has taken the lives of around 10 million people in 2020 according to the WHO (2021). On the worldwide scale, it is characterized as the leading cause of death, but comes second place in the U.S. after heart disease. Although to date no cure has been found, for many years medical professionals have generated a number of preventative measures to treat cancer, whether from early diagnosis techniques, to revolutionary treatments such as chemotherapy and radiotherapy. Not only does the disease cause the deterioration of health, but has a detrimental effect on mentality, as shown by

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the 20% increased suicide risk for cancer patients as compared to the general population, especially those who are terminally ill (Henson *et al.*, 2019).

Additionally, cancer patients commonly suffer from post-traumatic stress disorder characterized by undesirable flashbacks and nightmares, and symptoms could potentially cease to subside unless one resorts to treatment (Cancer.Net, 2019). Thus, over time, scientists have increasingly acknowledged the psychological burden that cancer brings, which led to their suggestion of palliative care, that could be monitored through several psychotherapies.

Psychological Interventions are non-pharmacological treatments administered to a wide variety of patients who seek to reconnect with themselves and their environment following a certain struggle that altered their thoughts and behavior. Those individuals, whether cancer patients or not, could be victims of mental disorders, seek adjustment to a certain change in their life, or even wish to value their self-worth and create more positive feelings about oneself. In this research, several topics are tackled, including: the use of clinically approved music therapy to harness the therapeutic effects of music for stress management; the practice of positive psychotherapy to focus on post-traumatic personal growth; the practice of hypnosis to exploit mind's power in controlling symptoms; as well as a variety of other techniques aimed at reducing emotional burden of patients.

The psychological ramifications of this paper involve improving mental welfare and coping with cancer through the therapies, while shedding light on some biological aspects that involve effects on the human body, including how psychotherapies affect immune system functioning, blood pressure and circulation, and neurotransmitter release. Therefore, due to the frequency of the disease in today's society and the predisposition of relating a cancer diagnosis to death, it is very important to not only focus on the health aspect of the disease, but to monitor psychological wellbeing of cancer patients. The side-effects of the disease include immense pain and mental degradation, leading patients to resort to self-harm or drug use to relieve their burden and thus, are at risk of overdose. Accordingly, it is crucial to incorporate psychotherapies into their routines. Despite the crucial role that medical treatments play in cancer patients' lives, psychological interventions such as music and art therapy, hypnotherapy, and positive psychotherapy, among others, have been proven to help adult American patients cope with anxiety and stress, promote personal growth, and manage unpleasant physical symptoms.

Application History of Psychological Interventions

The history of psycho-oncology does not date as far back as the history of medical oncology, and is a relatively recent approach that begun in the United States in the mid-1970s when it started gaining recognition from scientists and the public. This late acknowledgement comes from a variety of reasons, for a cancer diagnosis during those times evoked silence among patients and was to be unspoken of, not to mention the strong stigma against mental illnesses, considered to be equally feared as cancer, eventually causing scientists to refute the idea of studying the effects of psychological treatments and their potential in improving patients' lives (Holland, 2002). With the establishment of *The Journal of Psychosocial Oncology* in 1983, the first of its kind to provide research on psycho-oncology, medical professionals gradually implemented several interventions that are now available in most hospitals and cancer centers as Holland (2002)

stated. Although the adoption of these interventions began in the 20th century, they have existed for as far back as the 18th century, as the case with hypnotherapy discovered by Austrian physician Frans Mesmer (Lanska & Lanska, 2007) and art therapy founded by psychiatrist Paul-Max Simon (MacGregor, 2013). On the other hand, a number of contemporary approaches have been developed to aid with cancer patients' stress and anxiety including the Pythagorean Self-Awareness Intervention, that Charalampopoulou *et al.* (2020) described as a recent stress management technique that utilizes the 71 Golden Verses of the ancient Greek philosopher Pythagoras to enhance patients' self-consciousness and that of their surroundings. Moreover, positive psychotherapy is a new theory of well-being where psychologists aim to harness patients' inner strengths to build a more confident and resilient attitude when confronted with challenges (Arnedo & Casellas-Grau, 2015). Cognitive behavioural therapies, one of the most widely used interventions for psychological disorders, can be used to treat patients' common struggles such as insomnia and lack of self-worth, and works through reorienting distorted thoughts and behaviours by introducing new ways of coping in the face of obstacles.

Literature Review

Scientists and psychologists increasingly support the practice of nonmedical means to help ease the immense pain and distorted emotions that affect the everyday lives of cancer patients. To relieve those symptoms, researchers analysed interventions such as hypnotherapy for reducing unpleasant physical symptoms, positive psychotherapy and meditation to improve the quality of life and finally, art and music therapy as well as Pythagorean Self-Awareness intervention to alleviate anxiety and stress. This review of scientific research critically analyses scholarly articles to point out the extent to which psychological therapies benefit adult cancer patients in the United States.

Regarding Art and Music Therapy, Kievisiene *et al.* (2020) harnessed the therapeutic effects of art therapy where results denoted enhanced quality of life as well as a decline in severe emotional distress, as compared to the research by Nainis *et al.* (2006) where 8 out of the 9 symptoms including stress and anxiety showed decline. Music therapy played a larger role on anxiety reduction by inducing preoperative comfort. Although Charalampopoulou *et al.* (2020) conducted the Pythagorean self-awareness intervention, which employs Pythagoras philosophies for stress-management, results were consistent with the findings of the formerly mentioned authors, which showed enhancement in the PSAI group's sleep quality, as well as a reduction in depression, anxiety and stress symptoms as compared with the control group. Moreover, while Kievisiene *et al.* (2020) studied evidence-based set of research, Nainis *et al.* (2006) and Charalampopoulou *et al.* (2020) engaged in direct interaction with patients older than 18 years of age. Additionally, Charalampopoulou *et al.* (2020) utilized questionnaires, Likert scales, and examined hair cortisol concentrations.

Positive psychotherapy uses a balanced plan comprised of enhancing the strengths and virtues of the patient, along with overcoming all the defects caused by cancer or chemotherapy (Casellas-Grau *et al.*, 2013). Salsman *et al.* (2019) touched upon the extensive negative repercussions of chemotherapy on the mind and body, as with Casellas-Grau *et al.* (2013), who specifically discussed the distortion in patients' conceptualization of their selves and their overall affect. By working on patients' mindset of being present in the moment along with enhancing sense of meaning, results have shown improved self-esteem, optimism, and increased life satisfaction for

an overall healthy development. Similarly, the outcomes of the second study by Salsman *et al.* (2019) showed positive affect being very prominent when investigating the efficacy of other psychosocial interventions. The authors also found in-person interventions as being more effective than web-based ones, which wasn't necessarily an issue according to Casellas-Grau *et al.* (2013). Both studies found out that the positive affect and overall feelings generated by the interventions had carry-over to many other life domains, promoting livelier life experiences.

Hypnotherapy has been used as a non-medical analgesic for the treatment of unpleasant physical symptoms associated with cancer treatment. Through the biological scope, hypnotherapy modulates pain by influencing neural networks in the brain (Wortzel & Spiegel, 2017). Although Cramer *et al.* (2014) did not discuss the scientific approach, they emphasized the role of patients' expectancies in determining the results of the intervention, whereas Wortzel and Spiegel (2017) used a different definition, hypnotisability, to predict the patients' response to hypnosis. Another intervention, mindfulness meditation, was demonstrated by Ngamkham *et al.* (2019) who used different methodology that employed programs focusing on breath control, loving-kindness practice, and yoga. All three articles showed common outcomes in the effect of interventions on physical distress symptoms. For instance, Wortzel and Spiegel (2017) concluded that practicing self-hypnosis resulted in pain reduction over a period of one year, which is consistent with the findings of Cramer *et al.* (2014) where preoperative hypnosis reduced a variety of unpleasant physical symptoms post-surgery. Ngamkham *et al.* (2019) similarly concluded that pain management proved to be the primary outcome over the course of 6 months. It is worth mentioning that Wortzel and Spiegel (2017) and Ngamkham *et al.* (2019) noted that their interventions involved drawing cognitive attention *away* from the painful stimulus through effortful focus on distractions.

Despite being significant empirical and evidence-based articles, all posed a common problem in the lack of sufficient samples that allow generalization to the wider population. For instance, the systematic review of Cramer *et al.* (2014) showed a small total number of eligible RCTs similar to that of Charalampopoulou *et al.* (2020), Kievisienne *et al.* (2020), and Ngamkham *et al.* (2019), where only 11 out of 200 studies met the inclusion criteria, and only three databases were searched, which questions the extent to which the accumulated evidence could generalize to all cancer patients. Research results of Cramer *et al.* (2014) seem to be exceedingly preliminary as they relied on single studies of the effects of hypnotherapy. Furthermore, the arguments of Wortzel and Spiegel (2017) demonstrated greater persuasiveness due to their more scientific approach to hypnotherapy, rendering the research more influential, as well as the greater inclusivity in their samples unlike Cramer *et al.* (2014) who studied only breast cancer patients. Salsman *et al.* (2019) produced more promising results in patients with early-stage cancer compared to ones with late-stage cancer, which hinders generalization to all cancer patients.

The accumulated evidence provided by these three sources is consistent with the research question at hand, and accurately tackles the effect of psychological interventions, in this case art and music therapy, Pythagorean Self-Awareness intervention, positive psychotherapy, hypnotherapy and mindfulness meditation, on reducing the unpleasant symptoms, whether physical or emotional, that accompany cancer treatment.

To sum up, the impact of the different psychological interventions is clearly demonstrat-

ed in numerous literatures. Future research should aim at increasing sample sizes and varying participant backgrounds since most studies undertake small sample sizes, limiting the extent to which results could be generalized onto other cancer patients from different cultures and backgrounds. The goal is to produce reliable results, and hopefully future research can continue to replicate those indispensable outcomes.

Techniques to Recover Mental Health and Peace of Mind

Many cancer patients are bombarded with day-to-day emotional battles accompanying painful medical treatments, which is why recent interventions such as art and music therapy, and Pythagorean Self-Awareness Intervention have been developed to reduce anxiety and stress symptoms. For instance, art therapy is a novel technique that emphasizes the importance of creativity in improving one's mental state, as it allows freedom of expression through different art forms such as painting, drawing, and colouring. Patients initially doubted the efficacy of merely colouring on a canvas, especially those who lacked artistic skills, however, research by Nains *et al.* (2006) that assessed patients' feelings showed significant results that reported a decrease in levels of tiredness, pain, anxiety, and depression. Patients practicing art therapy described how they achieved "*a feeling of control and comfort*" (Nains *et al.*, 2006, p. 166). On another note, Kievisienne *et al.* (2020), approached this type of study differently where the research compared art therapy groups vs. SHAM groups (that painted drawn shapes without emphasis on emotion). Although both groups experienced similar side-effects of chemotherapy, the art therapy group exhibited a significant decrease in depression and anxiety levels, as well as an increase in emotional awareness and acceptance. Results of other reviewed studies by Kievisienne *et al.* (2020) displayed improved cerebral blood flow, general health, and quality of life. The authors mentioned that the creativity that art therapy evoked in patients could also be achieved in many other ways, whether through creative writing, poetry, dancing, or even creating videos. All these methods have been shown to ease the worries of distressed patients, slow down their heart rate, and provoke relaxed sensations. According to Khalil *et al.* (2019), engagement in creative activities led to an increased release of dopamine, the pleasure hormone that enhances sensations of satisfaction and happiness.

Another psychological intervention that plays an important role in the management of stress and anxiety is music therapy, and involves establishing a link between the emotional needs of an individual and music. Stanczyk (2011) divided music therapy into active, where patients were given the opportunity to freely express their feelings by experimenting with instruments, and passive, where patients listened to either live or recorded music. The implementation of these methods in the hospital setting gave patients serenity, greater peace of mind, and better emotional responses to their treatments and disease in general. In the systematic review of Kievisienne *et al.* (2020), the experimental group that listened to music before chemotherapy sessions reported a reduction in anxiety levels, as well as had a shorter hospital stay in contrast with the control group that was not exposed to any music; performing at-home music therapy also showed comparable effects. Similar results appeared in research by Wilson *et al.* (2011), with decreased levels of post-operative depression, stress, pain and blood pressure, as well as improvement in mood and quality of life. By concentrating on the soothing sounds, music and the beat

of songs, anxiety can be modulated through reducing heart rate and nervousness, leading to improved respiration and relaxed muscles. In the reduction of stress levels, music therapy does so by inhibiting cortisol secretion, an important stress hormone, whereby elevated levels could destroy the immune system. It is worth mentioning that listening to music improved blood flow between organs, as well as decreased nervous system arousal, which is the primary indicator of stress as mentioned by Hanser *et al.* (2006).

The Pythagorean Self-Awareness Intervention (PSAI) allows patients to identify the source of their negative life stressors and, hence, provides the opportunity to evaluate their own behaviour in an objective way by using the 71 Golden Verses written by the Greek philosopher Pythagoras. Charalampopoulou *et al.* (2020) divided two groups, the PSAI group and the control group, where results of the former showed improved overall mental health compared to the control group. At the same time, results indicated a decrease in (hair) cortisol levels, the primary stress hormone which also plays an important role in high anxiety levels, blood pressure and extreme fatigue, and can pose serious health problems like diabetes and muscle weakness, if present at dangerous levels. Upon the decrease in their levels of cortisol, patients noticed an improved quality of sleep and quality of life in general. DMN, the key element to evaluate all of these symptoms, is a metacognitive process, which allows patients to re-evaluate their choices and aim to make the right ones through self-observation and self-assessment. Charalampopoulou *et al.* (2020) stated that the intervention teaches patients to recognize their self-worth, overcome any bad thoughts associated with the experience of anxiety and depression, and provide methods to alter these thoughts into more positive ones. Once these negative feelings were under control, cortisol levels automatically dropped, which eventually led to a better quality of life.

Handling stress and anxiety is the key to a healthy lifestyle among those who suffer from these symptoms, and – if left untreated – the disorder could interfere with and delay recovery time. Cancer, in general, from the moment of diagnosis has the potential to draw negative thoughts into the mind of a patient, causing a rapid deterioration of mental and physical health. Chemotherapy has already had its adverse effects on the body, which is why it is essential for patients to keep their mental health in check, in order to boost their physical health. Art and music therapy are also non-invasive and inexpensive methods that can go a long way in benefitting cancer patients, all the while preventing the life-threatening effects that could potentially result from drug use of antidepressants to cope with distresses. All in all, dealing with anxiety and stress remains a crucial aspect of a cancer patient's life, which can be accomplished with the availability of several interventions like art and music therapy, as well as the Pythagorean Self-Awareness Intervention.

Methods to Amplify Positive Qualities and Attitude Towards Oneself

One of the negative outcomes that usually accompany cancer patients is the deterioration of personal growth qualities such as self-esteem and optimism, self-realization, and body positivity, which necessitates the redevelopment of these qualities through hypnotherapy, positive psychology, and cognitive behavioural therapy. Hypnosis is traditionally defined as "a state of consciousness involving focused attention and reduced peripheral awareness characterized by an enhanced capacity for response to suggestion" (Elkins *et al.*, 2015, p. 382). Yet, hypnotherapy has been one of

the least used interventions in the pursuit of cancer treatment, as mentioned by Owens *et al.* (2009), but when employed, has consistently produced reliable results concerning improved qualities, such as optimism and self-esteem. Self-esteem is a feeling characterized by accepting and respecting oneself and being confident in one's abilities, while optimism is described as having a positive outlook on the future and the expectation of positive outcomes. Téllez *et al.* (2017) conducted a study on those qualities in particular, by holding 24 group hypnotherapy sessions that primarily focused on hypnotic inductions and encouraging the participants to write about their subjective experiences, as well as imagination techniques prompting participants to envision their immune system functioning optimally and in prime position to fight off all cancer cells. The hypnotherapy group showed significant improvements on multiple scales, compared to the control group. Moreover, measurements of improved optimism and self-esteem were strongly maintained for the second half of treatments (the latter 12 sessions), as compared with the analysis of other symptoms, thereby strengthening the results. Laidlaw *et al.* (2005) studied self-hypnosis' effect on mood and outlook on life. After three months of practice, the self-hypnosis group reported improvements in mood, and that the practice *"gave them confidence and a sense of control back into their lives"* (Laidlaw *et al.*, 2005, p. 90).

Another intervention, Positive Psychotherapy, combines the traditional and modern therapeutic approaches by not only working on damage repair, but also placing great emphasis on human virtues and positive resources (Arnedo & Casellas-Grau, 2015). Post-Traumatic Growth (PTG) is the term used to describe increased self-esteem and confidence, as well as new-found appreciation of life, increased interest in spiritual matters, and better understanding of the meaning of life. A crucial underlying assumption of Positive Psychotherapy is that humans have an innate predisposition to, not only settle for avoiding sorrow and regression, but also seek joy and personal growth. This intervention is primarily used as a group-based intervention to enhance interpersonal skills, but could also be applied in one-on-one settings. Arnedo and Casellas-Grau (2015) conducted a study to measure the influence of Positive Psychotherapy on PTG. The sessions, conducted over a period of 12 weeks, were not identical but spread across four different modules with the first two aimed at processing and accepting the cancer experience, and the final two focused on the personal growth and transformation after said experience. The results were very promising, as PTG was strongly reported, especially with regards to searching for meaning and awareness of positive emotions. Also, Saeedi *et al.* (2019) conducted a similar study with the sessions being slightly more intensive, but similar results were obtained, as the group receiving the therapy showed a significant increase in meaning of life and goal seeking compared to the one receiving medical treatment only. Personal growth can therefore be achieved through therapies such as Positive Psychotherapy, which manage to renew a cancer patient's view toward oneself and the world.

Cancer patients could also achieve psychological improvement in the form of Cognitive Behavioural Therapy (CBT), that relies mainly on re-educating patients through behavioural approaches, assuming that behaviours are learned, and changing the patient's dysfunctional thinking through cognitive treatments. The CBT sessions, as conducted by Bottomley *et al.* (2008), consisted of 8 sessions. The first three were focused on behavioural techniques, such as relaxation, and the next five sessions were cognition-based and dealt with altering distortions in the patient's thinking, by giving

brief lectures and holding group discussions. After assessing the differences between the control group and the one receiving the treatment, the latter showed a prominent increase on 'fighting spirit' scores and a decrease on 'helplessness' scores compared to the former, which received only medical interventions. These results indicate that CBT stimulated a more positive outlook on the future, thus motivating patients to fight their disease and to avoid rolling over in defeat. Harorani *et al.* (2020), who provided participants with a relaxed environment, verified the direct correlation between performing relaxation techniques and a cancer patient's heightened self-esteem. A unique use for CBT focused on improving a patient's perception of their body image (Fingeret *et al.*, 2013). Cancer patients commonly experience body-image struggles, resulting from hair loss, scars, and weight loss due to intensive treatments, however, research done using CBT to combat these self-demeaning thoughts has shown significant advances in body acceptance, which can translate over to feelings of optimism and self-esteem (Fingeret *et al.*, 2013).

Cancer is a mentally and physically draining disease, and chemotherapy is an even more debilitating process, causing patients to likely lose many of their positive qualities throughout this battle. In addition, they have to deal with massive bodily alterations that can go a long way, distorting their self-esteem and self-worth. Therefore, it is of utmost importance to monitor the thoughts and feelings of cancer patients and intervene to ensure their self-worth and identity remain intact.

To sum up, with the onset of cancer and its crippling symptoms, patients develop an impaired outlook on themselves and the world around them, along with a noticeable decrease in most positive qualities one can possess, like self-esteem, self-realization, meaning of life, as well as body image. This makes it continuously essential to shed light on the psychological interventions mentioned to help those in dire need.

Means to Managing Discomforting Physical Symptoms

With intense cancer treatment always comes a variety of unpleasant physical symptoms affecting many cancer patients such as pain and nausea, fatigue, and insomnia, which could be reduced through a variety of effective brain-related interventions. One intervention for reducing pain and nausea is the practice of mind-altering hypnotherapy. After the 18th century, the founding father of hypnotherapy, Frans Mesmer, demonstrated pioneering research on the effects of hypnosis when treating medical cases, which in turn inspired the term "mesmerism", since hypnosis creates a captivated, altered state of consciousness (D. Lanska & J. Lanska, 2007). In fact, hypnotherapy *"has been used successfully for over 150 years in the reduction or elimination of surgical pain"* (Telléz *et al.*, 2017, p. 70). However, only recently have the effects of hypnotherapy on the brain been studied, where research by Wortzel and Spiegel (2017) affirmed the decreased activity of the anterior cingulate gyrus, an area in the brain that plays a part in modulating the pain network. In their research, hypnotherapy involved three main components: "sensory transformation", "sensory accommodation", and imagination (Wortzel & Spiegel, 2017, p. 7). The first transforms the conscious awareness of the painful stimulus to a benign feeling, the second involves an alteration in the patient's perception of pain to a less painful or even more pleasant one, and the third instructs the patient to visualize their presence in a more peaceful surrounding, such as the beach. In the research by Elkins *et al.* (2007), each reviewed study showed signif-

icant pain reduction in patients undergoing standard hypnotic procedures compared with the intervention-free groups. Also, patients, who actively practice self-hypnosis on a daily basis, sometimes by listening to recorded audio tapes, show to have benefitted from the intervention that reduced their chronic pain.

To add, practicing mindfulness meditation, a common relaxation technique used by many, has shown to be effective in reducing fatigue among cancer patients and altering their cognitive appraisal of pain. Meditation is a mental exercise originating in the East, particularly prevalent among Buddhists, that involves drawing attention away from the painful stimulus and focusing on distracting stimuli, such as peaceful and optimistic thoughts as stated by Ngamkham *et al.* (2019). For instance, the researchers administered different types of mindfulness-based interventions to cancer patients, each employed either breath control techniques, or loving-kindness practice, or yoga, or massage, among others. Results proved long term pain management to be the primary outcome of all four interventions. Cancer patients are remarkably susceptible to painful sensations, which they have lost control over due to the severity of their emotional response to pain, as well as the overwhelmed feelings their cancer diagnosis brings. Additional research provided by Chang and Knobf (2019) introduced the thousand-year-old Asian meditation practices, Qigong and Tai Chi, as methods to reduce cancer patients' chronic fatigue. Qigong exercise involves restoring a vital energy present in the healthy body, the "Qi", after its distortion due to illness. However, Tai Chi is a self-defense martial art that involves achieving a meditative state through slow, relaxed movements with an emphasis on breathing techniques, similar to Qigong exercise (Chang & Knobf, 2019). With gradual loss of physical ability that accompanies cancer treatment, Qigong helped restore strength among older U.S. patients, some of which were cancer survivors, who showed improvement in their daily 6-minute walks as compared to the control groups. There are a limited number of Tai Chi and Qigong professionals available in Western countries, which poses as a limitation for their implementation in medical centres.

Cognitive Behavioural Therapy is a standard psychological intervention for the treatment of insomnia especially among cancer patients, where sleep dysfunction is a frequent symptom that is *"reported to range from 30%–88%, which is almost twice the rate in the general population"* (Woodward, 2011, p. 42). This sleep disorder accompanies patients that suffer from psychological stressors, pain due to receiving intense medical treatments such as chemotherapy, among other unpleasant symptoms such as nausea, hot flashes, and diarrhoea, as described by Woodward (2011). However, insomnia can have detrimental effects on biological systems in the body, including reduced immune response and cognitive function. One type of Cognitive Behavioural Therapy, stimulus control, employs a number of procedures that the patient should follow to successfully enhance their sleep quality. Some include avoiding daytime naps, watching the clock, or doing some tiring activity before bedtime, as well as following a regular sleep schedule, and avoiding going to bed unless they feel sleepy. Results of this study by Woodward (2011) revealed a reinforced connection between the patient and bedtime, as demonstrated in the 179 breast cancer patients who reported improved sleep function and reduced insomnia. Another study conducted by Garland *et al.* (2014) produced similar results in which 150 post-treatment patients revealed reduced sleep latency, decreased nightly awakenings, and improved overall sleep. Cognitive Behavioural Therapy improved immune system functioning, as shown in a study of 57 breast cancer patients who by the end of the study,

were able to get 38 minutes of extra sleep per night, as well as increased secretion of cytokines – molecules that regulate immunity (Garland *et al.*, 2014).

For patients suffering from pain, nausea, insomnia, or any unpleasant physical symptom, it is important for physicians to be able too suggest complementary interventions to treat the symptoms that would otherwise gradually deteriorate a cancer patient's quality of life, from distorted functioning in daily life to cognitive decline (Woodward, 2011). These side-effects exhausted patients more than they already were, and increasingly breed feelings of hopelessness that eventually worsen symptoms already present and so increase risk of death. Hence, to sum up, those common unpleasant outcomes from chemotherapy or any cancer-related medical treatment makes alleviating these symptoms crucial through these psychological interventions, hypnotherapy, mindfulness meditation, and cognitive behavioural therapy, that all emphasize the power of the brain in its ability to reduce painful stimuli and control bodily processes.

Qualifications of the Research

Some limitations encountered during the course of this research include insufficient peer-reviewed articles covering cognitive behaviour therapy's effect on self-growth or Pythagorean Self Awareness intervention, being one of the latest developed interventions as compared with the others. Also, data from some studies could not be generalizable to the wider population due to their use of small samples. The ongoing COVID-19 pandemic presented a barrier for conducting live interviews with cancer patients, or even their physicians, to get their opinion on psychological interventions, and whether or not they would be interested in receiving them, in the case of the patients. Finally, the lack of time available to conduct surveys with cancer patients receiving psychotherapy imposed another difficulty for the research.

Conclusion

To conclude, the implementation of numerous psychotherapies in hospitals nowadays provides cancer patients with outlets for taking care of their mental and physical health that are expected to deteriorate following their diagnosis. The numerous articles that tackled the question of whether non-pharmacological interventions smoothen the process of overcoming this tough disease, all agreed on the many benefits that arise from their application. Although there exist many possible psychotherapies to treat a specific symptom, this paper reviewed the roles of music and art therapy, and Pythagorean Self-Awareness Intervention on anxiety and stress, as well as hypnotherapy, Cognitive Behavioural Therapy, and Positive Psychology on personal growth. Also, hypnotherapy, and Cognitive Behavioural Therapy were analysed, in addition to meditation, for their effectiveness in modulating painful and uncomfortable symptoms caused by the harsh cancer treatments. These (psycho)therapies not only aided in managing anxiety and stress, pain, and self-degrading thoughts, but provided patients with the motivation that they needed to continue with their fight, and even strengthened their immune system and blood circulation along the way. Moreover, the results did not only produce immediate benefits for the patient, but, in the long term, had the potential to prolong life, speed up recovery, and reduce hospital stay. The practice of hypnotherapy has been criticized in the past for being a form of mind control, which planted fear in patients' minds leading to their refusal of succumbing to the hypnotist. However, with the advancement of science and civilization, evidence for its

efficacy has reassured patients that although agreeing to the practice requires bravery, the outcomes would compensate and could lead to a variety of benefits for their mental and physical health. For a long time, cancer treatments have been almost purely fixated on the biological frame, overlooking the fact that the mind and the body work cooperatively. Disregarding cancer patients' coping difficulties has had a negative effect on their survival, leading to increased death rates throughout the years. Today, with those elevated cancer rates all over the world, it becomes increasingly important to offer those suffering a comprehensive course of treatment, which not only ensures their present, but their future well-being. Although currently adopted by many, there are still numerous individuals, from patients to scientists, who are unaware of the availability of such psychotherapies and their potential benefits, particularly in developing countries. Thus, it is as important to raise awareness on the matter, and encourage all medical institutes and hospitals to implement the techniques that could alleviate the burden off of cancer patients, especially those who are suffering alone. Scientists are yet to unravel fully the potential that psychological interventions can have, and thus, only extensive research will catapult for a bigger and better future.

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HOMAGE TO DAVID BOADELLA

‘Immersion in Deep Waters’: A Conversation with David Boadella on his Life’s Work[1]

Lily Anagnostopoulou

Lily Anagnostopoulou: *Dear David, you are turning 90 this year, and what a nice coincidence and an honor to be invited to interview you on your life’s work. Let me start with the present and go backwards in time. What is closest to your heart these days?*

David Boadella: Together with Silvia Boadella, I am very happy with how Biosynthesis has developed over the last thirty-five years – since 1985. Our hearts are deeply touched by the gratitude shown to us by our students and patients, and by our many trainers, including you, Lily, who have enriched Biosynthesis for many decades with their own unique creativity.

An important part of this development was when I founded the journal *Energy and Character*, in 1970, as a medium for publishing articles not only about Biosynthesis, but from the whole community of body psychotherapists. Peter Freudl created a content archive on the internet.

1. This article was first published in the *International Body Psychotherapy Journal*, Vol. 20, No. 1, 2021. It is published here with the kind permission of the author and IBPJ Editor.

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The past has sown the seeds for the present and for new developments in the future. Currently Silvia and I are completing a thousand-page book on our method, which we hope will be published in 2021.

LA: *I have known you for over 35 years, and what made me to want to meet you had no direct connection to psychotherapy. I had heard that you had written a thesis on D. H. Lawrence and the body. I was at the time reading all of his books, and I felt, Oh! here is a kindred soul. You didn't start as a psychotherapist. So, what brought you to the field, and how did your background influence your work? How important is it for psychotherapy to have roots in other fields of knowledge?*

DB: In 1950, I was deeply influenced by the English author D. H. Lawrence. His view of life, love, and sexuality was in many ways similar to Reich, who I discovered in 1952. My first book, *The Spiral Flame* (Ritter Press, 1956), explored these connections in depth. Against this background, I decided to train in education, where I could influence what Reich called "the children of the future." I took my training in Vegetotherapy in parallel, in the early fifties. For me, psychotherapy needs to link with re-education, social awareness, and somatic knowledge based on neuroscience. In addition, it needs to be open to explore the transpersonal roots of being human.

LA: *Who do you consider to be your great teachers, people you are grateful to, people you learned a lot from?*

DB: My most important influences, after Reich, were the following:

- *Paul Ritter*, with whom I trained for five years in Vegetotherapy.
- *Ola Raknes*, with whom I took additional Vegetotherapy sessions.
- *Nic Waal*, a Reichian doctor from Norway, who wrote me in 1952 warning of the importance of not pushing clients into catharsis if they had weak boundaries or borderline tendencies.
- *Stanley Keleman*, the founder of Formative Psychology in California, who was a close colleague and friend for sixty years.
- *Frank Lake*, who developed the understanding of polarity tendencies in character development. He was the founder of Clinical Theology, which emphasized the treatment of prenatal disturbances.
- *Bob Moore*, a Danish teacher of psychosomatic principles and energetic meditations.

LA: *In your long journey what did you find easy, what was difficult, and what was truly inspiring?*

DB: What I found easy was working with the body and learning to read body signals. I worked with my first client in 1956, and helped him to overcome his compulsive and rigid tendencies until he learned to trust himself enough to find his first secure relationship with a woman.

What I found difficult was organizing trainings. I traveled a lot at the invitation of others in many countries, but I was not a good organizer.

What was truly inspiring was my relationship with Silvia, who was and still is a very creative therapist and trainer, but also an exceptionally good organizer. She created the International Institute for Biosynthesis (IIBS) in Zürich in 1985, and we have combined our skills together ever since then.

LA: *As I grow older, I feel a certain inner alignment that is expressed in an inner certainty; something in me says, "I was right." Do you also feel this?*

DB: Yes, I have this feeling you describe when I can get beyond stress, relax, and learn to trust the deeper messages from my body, and be in contact with my deeper self and with the hearts of others. In Biosynthesis, this relates to what we call the essence, or what Donald Winnicott calls the "true self."

LA: *We say every method is somehow influenced by its creator. How do you think the person David Boadella shows through Biosynthesis?*

DB: I think a deep aspect of my personality is the understanding of the three lifestreams: centering, grounding, and facing. In 1975, I was offered a one-hour massage by three group members I had met in a weekend workshop in Albany, USA. Against all expectations, I accepted this offer. The session was the deepest I had experienced in my life, and lasted four hours after the massage was finished.

The session was given by a man, his wife, and his sister. The man had weak boundaries, but helped me to find my boundaries and to strengthen my grounding. His wife had problems with her own breathing, but helped me to go deeper into my center and trust my own inner rhythms. His sister had difficulties normally in making eye contact, but helped me face her and others with my deeper feelings.

On returning to England, I met Stanley Keleman, who told me that this five-hour session was like a baptism after immersion in deep waters. Out of this deep personal encounter, I learned to trust myself and others much more than before, and began to teach the principle of the three lifestreams, which is at the foundation of Biosynthesis. This also opened up important links to the understanding of embryology in its relation to the development of the body as a whole.

LA: *What criticisms have you received about Biosynthesis, and which ones do you consider to be valid? I know, for example, how you had to support concepts of energy and spirituality in modern views of psychotherapy, which have difficulty with the scientific aspect of these concepts.*

DB: We have received on the whole very little criticisms from within body psychotherapy. Rather, I have been invited to teach within many other modalities, which have welcomed learning about Biosynthesis. I always had good contact with Alexander Lowen and with Gerda Boyesen.

An exception is a recent critique of the transpersonal aspects of any therapy, including ours, from the Gestalt therapist Peter Schulthess, published in a Swiss journal of psychotherapy. This has opened a debate within the EAP, with many articles published on the relationship between psychotherapy and spirituality, including my response "Boundaries to the Transpersonal."

Also, my earlier article, "Essence and Ground" was first published by the EAP in the *International Journal of Psychotherapy*.

LA: *There have been great changes in body psychotherapy over its short life. Which ones do you like in particular?*

DB: Body psychotherapy began to organize its first congress in 1979, in Davos, Switzerland. I was elected as the first president of the EABP at Seefeld, Austria, in 1981. We created the Board and the various subcommittees, which have continued to this day. The biggest changes have been the emphasis on the importance of research and the publishing of an extensive bibliography of body psychotherapy books and articles.

LA: *How do you see the modern trend of supporting our work with neuroscience findings?*

DB: Neuroscience is an important part of psychosomatics, so an understanding of how the brain works is part of understanding the body.

David with his wife Silvia and son Till

However, we have to be very careful not to identify with reductive materialism, which sees the brain as creating the mind.

Many years ago, I received a letter from the quantum physicist David Bohm, who sent me his book *Wholeness and the Implicate Order*. Bohm was emphasizing mutual influences between matter and mind, without reducing one to the other. He called their interaction "soma significance." In Biosynthesis, we speak of soma semantics, the meanings of the body. An important chapter I wrote on this was published in the *Handbook of Body Psychotherapy* (Marlock *et al.*, 1985).

LA: *I think Biosynthesis is especially important today for young people as our culture becomes less and less embodied, and human contact becomes more and more virtual. What do you think?*

DB: Young people implies not only young adults, but also children. For nearly thirty years of my life, I worked with children in parallel with working with adults. Each process helped the other. My work with maladjusted children was the basis of my master's degree in education (1960). This work was influenced deeply by my therapeutic knowledge. An article published about me in an educational journal when I was a headmaster was called "The Head with the Healing Hands." The work with children also greatly helped my psychotherapeutic work with adults.

Both approaches involved embodiment and touch, which classical therapies avoid. In the corona age, verbal contact with clients, or school children, can be maintained, but touch goes out of reach.

In Biosynthesis, Silvia and I developed the concept of the four elements of touch at a workshop in Greece in 1984. The four elements are *earth touch* related to boundaries, *water touch* related to the flow of movement, *air touch* related to inner rhythms and breathing, and *fire touch* related to the transmission of warmth through the hands in the energy field. At the same time, we developed important principles regarding the ethics of touch. All this is much more difficult to communicate through virtual contact.

LA: *What is your vision for the future of Biosynthesis? How would you like to see it developing?*

DB: An important principle within Biosynthesis is the understanding of the seven life fields of experience. These are closely related to the seven segments of the body as recognized by Wilhelm Reich. The life fields are a common basis in all trainings in Biosynthesis which have developed in many countries.

Silvia and I formed the European Association for Biosynthesis (EABS) in 1988, the Overseas Association for Biosynthesis (OABS) in 1990, and the International Foundation for Biosynthesis (IFB) in 1991. Since then, many different national and regional institutes have been developed, led by creative trainers who invite leaders from other countries. Lily, you are yourself a wonderful example of what you have created in your own country, Greece, but

also in sharing your training skills with many Biosynthesis Institutes from other countries.

I hope very much that this mutual connectedness will continue during the coming years. It is greatly helped by Biosynthesis Institutes, organizing in different countries international therapist meetings, conferences and congresses.

LA: *Anything else you would like to add that I didn't give you the chance to talk about?*

DB: I would like to emphasize that there is in Biosynthesis a deep connection between theory and practice. This means that our students, or clients, are also our teachers, and that we learn new principles and methods in our interactions with the uniqueness of individual developments. In this sense, the therapist does not cure the client, but provides an environment of care within which the client is able to develop a self-cure.

LILY ANAGNOSTOPOULOU, PhD, is a psychologist and psychotherapist. She is the Founder and Director of the Greek Biosynthesis Centre, an International Senior Trainer in Biosynthesis, and President of EABS. She has a BA in psychology from Deree College, Greece, and a PhD from the University of Edinburgh, Scotland. She has studied Biosynthesis with David and Silvia Boadella, Bioenergetics with Alexander Lowen, hypnosis with Ernest Rossi and Nachi Alon, Group Analysis at the Institute for Group Analysis, Greece, Jungian Dream Analysis with Winnifred Rushforth, Rogerian Counseling at the University of Edinburgh, and Family Systems with Vasso Vassiliou. Lily has worked for many years as a psychotherapist in private practice, as a school psychologist, and a university teacher. Currently, she primarily works as an international trainer of Biosynthesis and likes big group events because of the powerful healing field they create.

A Personal Acknowledgement of David Boadella, His Life and Work

I'm very sad to say goodbye to David Boadella who died in November 2021.

I first met David in the early seventies when I attended one of his workshops at Acacia House. I had been in training since 1969 and then working in the staff team at the North London Polytechnic in the Applied Behavioral Science Division of the Management Studies Department. This was the beginning of the Humanistic movement in Britain and we taught organisational change, small and large group and inter-group dynamics, interpersonal skills, leadership and decision-making skills. We used 'experiential learning methods' based in the Humanistic principles that were emerging at that time. We saw ourselves as pioneers and revolutionaries. I think it was clear that we had subversive intentions to overthrow the status quo and create a brave new world of equality, justice and peace. It was still the Sixties after all.

I set this scene because it is important in understanding the context in which David came to mean so much to me.

I began to realise in the work we were doing at the Polytechnic, as creative and innovative as it was, that we came up against rigidity and limits within people that stopped them opening to their own experience and each other. It felt as if what we were doing only scratched the surface of the possibilities for change. I felt the need to look for deeper solutions. It was during the beginnings of this search that I came across David.

I remember him speaking at the beginning of his workshop about the possibility of a world where we were all open to the free flow of the life force within us and that this energy released our potential for connecting our hearts, minds, souls and bodies. In this way we would be able to fulfill our own potential and be fully present with each other: 'Centering', 'Grounding' and 'Facing' were the key concepts.

It really hit the spot for me, speaking to my idealistic hopes and dreams of a different and better world. Politics and how we live our lives as individuals came together for me at that moment in a way that I have never lost. This was in the days after we'd learned of Reich's theories on the 'Mass Psychology of Fascism' and before the concept of 'emotional intelligence' and ideas about the fundamental healing powers in the quality of relational contact became commonplace. It was in fact revolutionary at the time.

I have to say at this point, despite having a personal life that was in tatters, divorced and with two very young children to bring up on my own, it didn't occur to me that what I was embarking on was for my personal benefit. I was still in heroine mode – something I might say I have still not managed to shift – and saw this as part of my training to help others. I think many of us started in therapy at that time under this illusion. Therapy was seen as 'educative' rather than therapeutic or relating to mental disorder or illness. Mental illness was something different and carried with it shame and taboo. A dividing line was established about what was 'normal' behaviour and

what was mentally abnormal, and this marked out territory for different professionals to intervene – medical, psychological or educative. Sadly, this divide still dominates the way we understand human experience and the politics of provision of care for those struggling or not coping with life. In truth, we now know that there isn't a simple divide between mental ill-health and well-being and that it is a spectrum along which most of us travel all our lives. Psychotherapy can help at any point along this spectrum. However, the debate still rages about the role and usefulness of therapy in accompanying a soul in deep distress.

I remember at this workshop one of the things David said to me while my whole body was vibrating with life was that I was afraid of my own power. This still resonates with me today and while, at the time, I didn't understand what he meant, over the years I have learnt a lot more about it, how it manifests and where it comes from in my experience.

Shortly after this, he invited me and a colleague to be trained by him. He proposed an unusual scheme – we would meet fortnightly for an hour together. Alternate weeks, he would work with one of us and the other would assist him. This arrangement went on for seven years. It was an extraordinary privilege and deep learning experience. The training included attending workshops and learning theory, but this arrangement was the core.

David's way of working was to pay absolute attention to the smallest movement of life in the person's body. He would see it flickering and find creative ways to support this life and bring it into fruition. He would use contact to encourage the movement to increase, using his presence, his hands, his eyes or at times his whole body. It was miraculous to see a person coming fully alive time and time again, and to experience it myself. There was very little analysis and very few words, mostly none at all during the process. Often the discussion afterwards would ground the experience through dialogue between us. What did it mean for the person experiencing it? How did it appear to us accompanying the person? This dialogue was simple, but very profound.

I say of David that he gave me back my frozen insides – and there is no way of adequately thanking a person for such a gift.

I remember one particular session where I was the patient. During it – and towards the end - a terrifying scream emerged spontaneously from my belly. Afterwards, I connected it to images of my brother. David said to me that this had been an expression of core fear. I tell this because when I got home, across London, my children and partner said something strange had happened. My brother was in an upstairs room helping us with some plastering. Apparently from downstairs they heard him roaring like a raging, wild animal. My youngest son said to me 'Mum, it sounded just like a session'. I don't understand this experience of course. It is one of life's mysteries. But naturally it spoke to me of deep and powerful transpersonal resonances that transcend time and space and the limits of what we know about everyday conscious experience.

This was one of the most important contributions to body psychotherapy of David's work. He developed Reichian theory to encompass and integrate the physical, emotional and metaphysical or transpersonal elements of body process in a methodology that later became Biosynthesis.

After seven years, David said in one session to me and my colleague, 'It's time for us to stop – I think I've taught you everything I know'. I can't remember if that was it, or whether we had one last session. But whichever, it felt right. We accepted it as a rite of passage and felt we ended with his blessing.

He shortly afterwards asked me to join his training team in Japan, Switzerland and Germany. It was in Japan in 1982 that I first met Silvia, who was to become his wife. I witnessed the beginnings of their love which lasted till his death. David acknowledges Silvia's contributions as key to the theoretical development of much of the transpersonal and spiritual elements of Biosynthesis.

I remember at the time he was against building organisations or institutions because he thought they easily became rigid structures, dogged by power dynamics and the establishment of pecking orders. He preferred the idea of seeding the work far and wide – releasing its potential in others.

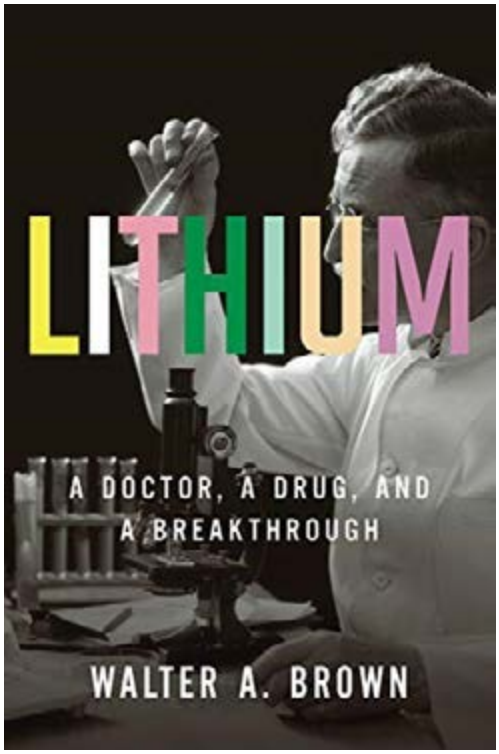
I was very pleased to be invited to attend the celebration of his life and work in a zoom which involved over 200 people from all around the world from Chile to Switzerland. I was thrilled to see the individual, different and creative ways people acknowledged David and his work using poetry, song and moving videos, expressing their cultural and physical landscapes. Their contributions were full of love and respect. They demonstrated to me David's legacy and how he had put this belief into practice. He was a man of integrity. He would have been so proud to see them. He was an 'educator' by profession and to his core. It was also clear how important to David Silvia's loving care of him had been in the last days of his life amidst the Covid pandemic. Their expression of this love through exchanging poems to each other that had begun in Japan continued to the last moments of his life.

He was one of the leading psychotherapists who brought the Humanistic movement to Britain in the early 70's. An internationally renowned author, he was also a scientist, innovative and creative theoretician, poet and a sensitive, attuned practitioner. But most importantly, he was a loving, generous, kind, patient and wise man.

I know many of you in our profession, particularly those in the Body Psychotherapy approaches will know him, or of him and his work. He will be a great loss to our tradition, but true to his word he has taught many of us to kindle the spark of life in others. What more can any of us as therapists try to do?

Tricia Scott,
MSc, UKCP Fellow

BOOK REVIEW 1



Lithium: A Doctor, A Drug, And A Breakthrough

Walter A. Brown

Reviewed by: *Susanne Vosmer*

New York: W.W. Norton & Co. (2020)
Hardback, Paperback, Kindle
272 pages
ISBN: 978-1631497902
RRP: £13.99; US$ 12.49, € 26.71

"I don't believe in God, but I believe in Lithium", Lowe provocatively wrote. A strong statement, which might offend, but indicates a degree of passion. Whether Walter Brown holds the same view is unknown, but he most certainly believes in the power of lithium. Through interweaving Lowe's moving narrative, Brown illustrates the impact lithium has had on sufferers from manic-depressive illness. He also takes the reader through the history of Bipolar Disorder and its conceptualization in psychiatry. Symptoms can be alleviated and prevented by Lithium without people having to suffer demonic effects of previous treatments, such as insulin comas, Electro-Convulsive Therapy (ECT), or lobotomies.

An American psychiatrist, Walter A. Brown tells a gruesome, but also captivating, story. He describes research studies in easily understandable language, includes French articles, and draws on email exchanges and interviews with Lithium pioneers to convey his fascination with this naturally occurring element.

John Cade's accidental discovery of the possibly positive effects of Lithium in 1949 represented a radical departure from prevailing ideas about the treatment of mental illness and launched a pharmacological revolution in psychiatry. In high doses, Lithium is toxic, and this is why frequent blood level measurements are necessary. When Cade experimented with Lithium, no pharmacological sources

were available to tell him what the right dosage for manic patients was. Faithful to medicine's ethical principle, *'First, Do No Harm'*, Cade took Lithium Citrate and Lithium Carbonate himself, before giving it to his patients. Without guidance, he managed to prescribe effective and safe doses. *"A doctor, a drug and a breakthrough"*, it becomes clear why Brown chose this title. He pays proper tribute to Cade.

Other major figures in the discovery and acceptance of Lithium include: Trautner, Schou, Lange, Talbott Blackwell and Shepherd. Nowadays, Lithium is no longer the 'Cinderella' of psychiatric drugs, or is it? Now approved in 50 countries, this miraculous mood stabilizer is widely used in the treatment of Bipolar Disorder. Brown admits that Lithium is not the perfect drug, it has its limitations and about 30% of patients do not benefit from it. However, Lithium has provided a normal life for millions of people, brought about a reduction in suicide, and saved billions of dollars in health care costs. That is impressive, if true.

Cade and the other pioneers become alive in the six chapters. At times, Brown's descriptions read like science fiction. But, it is better, due to real accounts of psychiatric illness and recovery owed to Lithium. A highly reactive element, which occurs throughout the earth's surface, Lithium bonds with other substances and only occurs in combination with these: for example, as Lithium Carbonate and Lithium Chloride.

Brown describes the slow acceptance of Lithium. Since it is a natural substance, drug companies cannot patent it, so it is of no real commercial interest. Other promoted drugs drew attention away from Lithium. But, Talbott and Trautner saved Lithium from the 'dustbin of medicine'. Brown's use of language provokes, but also disappoints. He makes *'Lithium'* intellectually accessible to the masses indeed, however, if you prefer scientific writing, this book might not be the best buy, even though it may tempt a younger generation of psychiatrists to review Lithium as an acceptable treatment option. The book also includes noteworthy historical anecdotes about psychopathology and concepts of normality. *"If homosexuality is seen as perverse and as an illness, surely deliberately inhaling large quantities of filthy disease producing smoke into one's lungs day after day should also be defined in similar terms"*, it was John Cade, who said this. *"Welcomed by the Catholic Church, which viewed Cade's beliefs as an antidote to those godless and repugnant psychoanalytic concepts, Cade did not dismiss psychoanalysis entirely"*, the author writes. Unless you share Brown's passion for Lithium, the question arises nevertheless as to why one would want to read 272 pages on this topic, but psychotherapists might find his writing style and content engaging. And, why did it take until 1969 for the approval of Lithium by the Food and Drug Administration in USA?

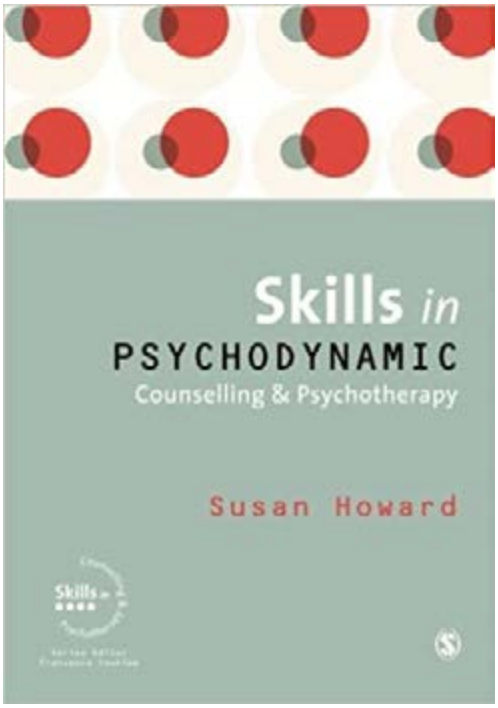
Psychoanalytic concepts dominated American psychiatry at the time. Some form of psychoanalytic therapy was the gold standard for treating almost all conditions of the mind. Psychiatric drugs were considered an accessory to bona fide treatment and were believed to interfere with the therapeutic process. Teachers in psychiatry were psychoanalysts in the late 1960s and early 1970s. Brown writes that he spent hours trying to get his patients to talk about their anger. Drugs were discouraged. Nowadays, he comments, this approach could probably amount to malpractice, because mental disorders are now viewed as brain diseases.

Several of Brown's stories make me wonder what function psychiatry serves. Whether mental illness is a disease, still remains questionable. That cycles of mania and crushing depression are devastating, less so. Films

counter stigma and educate, Brown demonstrates. In the thriller *Homeland*, Lithium keeps the protagonist sane. '*Does Lithium prevent manic episodes*?', Brown answers this question by describing the prophylaxis debate: apparently, it does. However, whether one should believe in Lithium, rather than God, is somewhat more debatable.

SUSANNE VOSMER, PhD, is a Group Analyst and Clinical Psychologist, who works at the University of Hull.

BOOK REVIEW 2



Skills in Psychodynamic Counselling & Psychotherapy (2nd Ed.)

Susan Howard

Reviewed by: *Susanne Vosmer*

London: Sage. (2017)
Hardcover; Paperback
176 pages
ISBN 978-1-4462-8567-1
RRP: £26.99; € 24.94; $40.20

Susan Howard writes an interesting book, which, however, requires some basic prior knowledge of concepts and theory. Perhaps this is not necessary, as she skilfully illustrates basic concepts, although the readers would benefit from knowing some psychodynamic theory. But then again, it is mainly a "how to do therapy" book.

Helpfully organised and systematically addressing major core competencies, Susan Howard's new second edition will be welcomed by trainees. It contains fourteen chapters, which start off by her very briefly outlining what psychodynamic theory and therapy are. Personal attributes, such as being able to mentalise, are described in Chapter Two. The reader can accompany Rona, Julia and Richard on their journeys of becoming qualified counsellors, at least, for a short duration. Having own therapy and being supervised are an important part of training in psychodynamic counselling. Infant observation, attending experiential groups, 'journaling', reading and ways to work with diversity, form part of the third chapter. These are short, but to the point.

The chapter on "Understanding the Brain and the Implications for Psychotherapy" explains crucial neuroscientific processes. Therapists, who like to convey to their clients the structural mechanisms underlying change, will find Howard's introduction to this rapidly expanding area of psychology quite useful. Throughout her book, suggestions for further reading are made, for example, Cozolino's (2016) and Wilkinson's (2006) work on how therapy changes minds. Recommended texts also include key authors in psychodynamic theory.

The features of the therapeutic frame are a 'therapy map' for Rona's first training client. Vignettes offer a glimpse into the normally hidden world of psychodynamic therapy. Furthermore, Howard provides advice on how to manage certain difficulties, for example, when clients do not pay, want contact outside the session, and how to set boundaries.

Novices gain insight into a first session, particularly how to establish a therapeutic alliance. Having "created the conditions that facilitate clients to bring unconscious preoccupation", they then need to "tune into" and "decode" their clients' unconscious. Typical techniques, for instance, free association, listening to and interpreting latent (unconscious) content, working with vertical splits of the mind and resistance, are skilfully illustrated in Chapter Seven.

In "The Theory Underlying Technique", a brief history of transference and counter-transference is given. Type of interpretations and how to interpret resemble a recipe book. But not quite. Beginners will find solace and comfort in these two chapters. It is not easy to interpret. 'Not' rushing into it, is certainly prudent. Inexperienced clinicians are reminded that they can wait, there is no need to hurry.

Psychic defences, and also working with these by using Milan's triangles, are outlined in Chapter Eleven. Basic defences (e.g. splitting, projection, projective identification) are easily understandable. Howard explains these beautifully.

Managing the therapeutic process, assessment and formulation, and evidence for psychodynamic therapy are addressed in the last three chapters of the current book. On the back of its cover, Hannigan states that it offers "an essential, contemporary and empirically informed overview of the necessary skills and qualities for effective psychodynamic therapy". Indeed, it does. I wish that this guide to practice had been written when I was training. Whilst it cannot equip readers with clinical expertise, which only comes with experience, it does provide an essential overview how to start.

Be this as it may, there is a plethora of books on the market. This begs the question why someone would buy Howard's latest edition. Well, there are several reasons. Often, psychodynamic writing can be mystifying, more obscure than revealing. The present book is one of those exceptions. Engaging, easy to grasp, the reader can dip in and out, without losing the thread. Howard uses a language, which is found in textbooks for psychologists. Hence, I would also recommend it to students and lecturers on courses in Clinical Psychology, particularly those courses that offer very little psychodynamic teaching. Such trainees should find this book very accessible.

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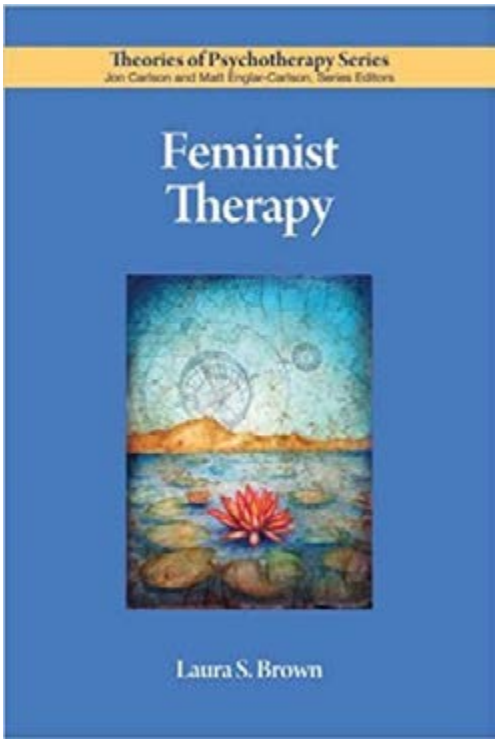
BOOK REVIEW 3



Feminist Therapy (2nd Edition)

Laura S. Brown

Reviewed by: *Amal Rohail, New York University*

Washington, DC:
American Psychological Association (2018)
Available in paperback and eBook
Paperback: 188 pages
ISBN 978-1-433-82911-6
RRP: £19.73; US$ 48.59; € 36.77

As a constituent of the American Psychological Association (APA) Theories of Psychotherapy Series, the second edition of *Feminist Therapy* highlights the contemporary model of feminist psychotherapy as well as its history and context. Laura S. Brown additionally draws upon her vast experience as a clinical psychologist as a reference to familiarize the reader with how feminist therapy is utilized in practice. Dr. Brown divides the book into seven chapters that collectively synthesize the various aspects of feminist therapy into one coherent model. The book begins with a discussion of the origins of feminist therapy and then delineates stages of its conceptual development by time period, ending with modern feminism in a globally connected world. This background enables the reader to understand the evolution and dynamic nature of feminist therapy as well as its inherent ties to the contemporary political climate.

Feminist therapy is then further contextualized with a description of the egalitarian theory that guides the model, along with its goals and potential areas of application. This conceptual section gives the reader an understanding of the different ideas that have shaped feminist therapy into its modern confrontation with patriarchal power, privilege, and oppression. Dr. Brown also includes an explanation of how this theory is applied in the therapy process. She illustrates this with case studies from her actual practice that serve as concrete examples

of the usefulness of feminist therapy. Finally, Dr. Brown ends with a promising summary of the current body of related evidence-based research, and acknowledges that this relatively young model has much room for future development.

A notion that is refuted early on in the text and then is continually referenced is the idea that feminist theory is exclusive to cisgender females. Dr. Brown clarifies that *"feminist therapy is practiced by people of all genders, with every possible type and configuration of client,"* (p. 9) due to the fact that all people are affected by patriarchal norms in the psycho-social environment. This explanation is critical in understanding the practicality of feminist therapy because it frames it as being applicable to everyone. As a result, the reader is able to appreciate the value of feminist theory as it is operationalized. Dr. Brown also repeatedly specifies that this model is distinctive in its focus on analyzing gender, power, and social location. Because this is a theory that is young in comparison to other schools of psychotherapy, the specific focus validates the existence of feminist therapy as its own unique model. The bulk of the book is focused on the theory behind feminist therapy, which is essential in understanding the fundamentals of feminism and how notions of gender, identity, distress, and power can play out in both society as a whole and within the context of therapy. Dr. Brown addresses the positioning of therapists as inherent holders of power, but also recognizes that the ability of a feminist therapist to recognize their power and privilege encourages empowerment of the client and promotes equality in their relationship (p. 62). She also emphasizes the use of the four biopsychosocial/spiritual axes of personal power and even includes a table (p. 41) that compares their interactions and exchanges and makes the concept easier to understand. Because there is no single founding scholar of feminist theory, Dr. Brown's in-depth discussion of theory and inclusion of various and sometimes opposing viewpoints in this section is critical in grasping the wide scope of this theory and its centrality on power.

Another strong point of the book is Dr. Brown's integration of case studies in the description of the therapy process. She includes strategies and examples from her own practice for each of the four axes of power. Without the inclusion of these real-world examples, the text would be too theoretical for practical application. This also opens up space for examination of potential challenges in the use of feminist therapy, such as its application in the current political climate (p. 117). This section of the book is integral to its success as a pragmatic model of therapy.

This book appeals to a wide range of readers, from feminists interested in learning about theory to aspiring or curious therapists, and even just a casual reader. While it is focused on therapy, it also discusses principles that are applicable to people from all walks of life. Feminist Therapy successfully presents a comprehensive understanding of feminist therapy as a stand-alone model of psychotherapy that is constantly improving and evolving.

LAURA S. BROWN, PhD, is a practicing clinician and forensic psychologist in Seattle and has served on the faculties of Southern Illinois University, the University of Washington, and the Washington School of Professional Psychology. She has received numerous awards, including

the Distinguished Publications Award of the Association for Women in Psychology, APA's Award for Distinguished Professional Contributions to Public Service, the Sarah Haley Memorial Award for Clinical Excellence from the International Society for Traumatic Stress Studies, and the Carolyn Wood Sherif Award from the Society for the Psychology of Women.

AMAL ROHAIL studies Global Public Health and Anthropology with a focus on Chemistry and Chinese at New York University, where she is expected to graduate in May 2020. She is on the pre-medical track and has conducted research regarding hepatic encephalopathy and hepatitis C. In addition to working for IJP, she writes reviews for *Somatic Psychotherapy Today*.

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Martha Straus is a professor in Clinical Psychology at Antioch University in New Hampshire, USA and part-time Lecturer in the Program of Professional Education at Smith College for Social Work. Martha is an international trainer, speaking on topics related to child, adolescent, and family development, attachment, trauma, and psychotherapy.

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Thomas Joiner is The Robert O. Lawton Distinguished Professor in the Department of Psychology at Florida State University (FSU). Author of over 750 peer-reviewed publications, Thomas is the Editor-in-Chief of the journal Suicide & Life-Threatening Behavior. He is a consultant to NASA's Human Research Program and is the Director of the DoD-funded Military Suicide Research Consortium.

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On behalf if the Executive team of the IX World C hotherapy,

Sofiya Kamalova,
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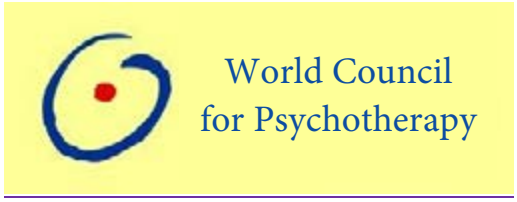

STATEMENT FROM THE WORLD COUNCIL FOR PSYCHOTHERAPY TO THE RUSSIAN GOVERNMENT

The World Council for Psychotherapy calls upon the Russian Government to immediately cease the invasion of Ukraine; stop the war; respect the law of nations; and bring back all Russian troops and weapons to their home country.

It is our view as Psychotherapists that a military invasion never solves problems, and never achieves its intended aims. Instead it creates immense damage, and causes destruction on many levels which can reverberate through the generations. This includes the personal suffering and deep trauma of both families and individuals at somatic, mental and emotional levels. Psychotherapists are committed to peaceful negotiation, dialogue and debate in conflict resolution, and we condemn war and violence. We call upon the Russian Government to stop the war, and establish peace through diplomacy in a thoughtful and mutually respectful manner.

We hope that the highest principles of the human spirit will prevail, and with all our hearts we wish that a resolution can be found which will restore freedom.

ЗАЯВЛЕНИЕ ВСЕМИРНОГО КОНГРЕССА ПО ПСИХОТЕРАПИИ В АДРЕС ПРАВИТЕЛЬСТВА РОССИЙСКОЙ ФЕДЕРАЦИИ

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