Crowded Intimacy - Engaging Multiple Enactments in Complex Trauma Work: An Embodied Relational Approach

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Introduction

My aim in this paper is to introduce relational Body Psychotherapy and its relevance to working with trauma. The term 'relational' is now widely used; it has recently become fashionable and most practitioners accept that "it is the relationship that matters" (title of BACP conference 2006, London). However, what being 'relational' actually means in the context of trauma treatment is a more complex question than many trauma specialists have considered (see Dworkin's (2005) book: *EMDR and the Relational Imperative*).

In the field of Body Psychotherapy there are two well-known approaches to working with trauma: Somatic Trauma Therapy as taught by Babette Rothschild and Sensori-Motor as advocated by Bessel van der Kolk and taught by Pat Ogden.

Body Psychotherapy, itself, dates back some 80 years, with a substantial history before its recent resurgence, having pioneered psychotherapeutic theories and ways of working rooted in - what today we would call - a holistic-systemic paradigm. Many of its basic principles regarding the interweaving of body, mind, feelings and psyche - at the time intuitively grasped rather than scientifically proven - are now being confirmed by modern neuroscience.

The history of Body Psychotherapy also includes controversies and prejudices relating to the way it was practiced in the 1970's and 1980's by some therapists who provoked and pushed clients into cathartic abreactions with no boundaries around the way they touched them. This is not the kind of Body Psychotherapy I intend to present.

To show how both 'relational' and Body Psychotherapy perspectives can profoundly enhance trauma work, I will start by clarifying my understanding of these two terms.

What do I mean by 'relational' ?

Bruce Perry (2006), an American psychiatrist, has developed what he considers to be a relational approach to working with traumatised children, known as Neuro-Sequential therapy.

This is based on his findings and research during the 1990's when he discovered that trauma interrupts the neuro-psychological development of children and fixates the child at that point in time when the trauma happened. In working with children from neglectful and abusive families, he postulates that the interrupted development can be restored by providing - systematically and persistently - the kind of parenting responses that were missing at the time. In this way, new relational experiences in the contact with the therapist reveal the brain's underlying capacity for neuro-plasticity. Perry claims that this kind of treatment creates new neural pathways, thus providing the anatomical basis for repairing arrested development and recovering from trauma. The children's fixation at early stages of development interferes with and damages their capacity for what the neuro-psychoanalyst Schore (2003) calls 'auto-regulation', keeping them either stuck in numb dissociation or in feeling overwhelmed by unbearable intensities of feeling, or helplessly oscillating between these two extreme states.

Perry considers his approach as a relational one, because the main therapeutic agent is the caring, loving, re-parenting relationship between patient and therapist. I agree with Perry that the reparative, re-parenting, inter-subjective regulation function is an important aspect of the therapeutic relationship generally, and trauma work in particular. However, I am aware that there are other therapists and approaches in the field who would dispute the idea that Perry's method is 'relational', who would question whether being 'relational' can be reduced to the provision of a reparative relationship. There exist very different, and contradictory, ideas as to what qualifies as 'relational' and I think it is important to not gloss over these differences. So what are these differences, and what can we learn from them? And if Perry's approach cannot be considered relational, then what can ? To illustrate some other forms and depths of relating that are not included in Perry's conceptualisation of 'relational,' I would like to share with you a vignette of my work.

Case Vignette 1

Sarah was struggling to free herself from the clutch of the arms that held her, but as much as she wriggled and pushed, the arms were stronger than her and did not let go. She was crying, frustration and fury mixed with her tears as her body was thrusting, fighting against the restraint. If she could, she would scream, but Sarah never screamed; she had been told very early on to be quiet, otherwise it would hurt more. So even now, 15 years later, she could not find her voice, and her distress was, as always, silent. She could feel the warmth of the body kneeling behind her, she could feel the strength of the arms holding her tightly and somewhere inside she knew she could not win. A little girl cannot win against adults. She knew that very well. This time, however, she was surprised to feel some relief in knowing that the other person was stronger than her. This time it was reassuring, and she could almost surrender. But the forces inside her were not ready to let go. She tried pleading. In a little girl's voice she was begging: "Please, please, just for a little bit, I won't do it too much ... ." "No", came the voice from behind her, firm and clear. "I do not want you to hurt yourself, you were hurt enough."

The arms were mine, the place was my consulting room, the year 2009. Sarah was not a little girl anymore but a 30-year-old woman, who had been in therapy with me for the past four years. We had been through this before. Sarah had a strong urge to hurt herself, especially when intense suppressed feelings were rising within her. Over the course of the first three years of therapy I had been told about her suicide attempts, all four of them - mostly by hanging - about severe self-harm and other forms of self-abuse. By now, Sarah trusted me enough to invite me into her tortured daily reality. No more talking about it; now I was offered the experience of it. And what an experience it was!
"But I have to, I have to!" she pleaded, trying again to bang her head against the wall. We were both kneeling on the carpet, near the mattress where so many times I had held her in my arms whilst she whispered to me in a little girl's voice, reliving years of sexual and physical abuse; an emotional, psychological and physical web of horror. "No," I repeated. "You were hurt enough." I knew I was right. Sarah's whispered stories revealed an unimaginable universe, in which some adults were taking pleasure in tying, hanging and suffocating a little girl, inserting sharp objects into her vagina, raping her in every way possible and playing cruel, sadistic psychological mind-games with her. She was hurt enough, in fact, psychologically, she was barely surviving.

What was driving this compulsion to hurt herself further, I wondered ? Was she trying to gain some control over the abuse by volunteering to hurt herself or was she at the mercy of an internal abuser who was continuing to use her for his purposes in the same way that the original, external abuser had used her ? In the moment, I did not have the luxury of dwelling on my thoughts. The intensity of what was happening between us, what was happening *to* us, demanded all of me. Sarah was still struggling to free herself from my arms. I knew, from previous experience, that if I let her go, she *would* bang her head strongly, repeatedly, against the wall until she would bleed. I also knew that when she woke up from her 'trance', she would be overcome with guilt, shame and regret. And she would be convinced that the worst that could happen was indeed now going to happen: that I would not agree to work with her any more. That I - like so many other therapists in the past – would back away from her inner madness and leave her to face it on her own. I knew that she would plead with me to forgive her for putting me through it and beg me to give her one more chance, she would promise to control herself next time, to never do it again, and she would really mean it. The healthy part of her would really mean it. But when the internalised abuser took over again, she would be out of control, as she always is when she self-harms, as she is now, in the room with me. I knew all that because we had been through this cycle several times before. "And here we are again," I thought, "I am failing her as a therapist, I am really crap, why can't I do something helpful here? Something clever? If Pat Ogden or Babette Rothschild were here, they would know exactly what to do! In fact, I am sure it is so obvious that *anybody* would know what to do! I am just too stupid and ignorant. Maybe I should resign and never work as a therapist again? I am obviously not worthy to call myself one."

This harsh, judgmental voice was familiar. I had been in close partnership with my inner judge for years and, through the ups and downs of our relationship, I had learned to know, accept and sometimes even love the wound it voiced. But this time, the onslaught was harsher, pushing me to

admit my absolute failure as a therapist, perhaps even as a human being. I had some fleeting images of myself standing in the city centre, naked, beating myself up, tearing my hair, confessing my crimes of pride and grandiosity whilst the crowd laughed and threw rotten tomatoes and stones in my face. I felt lower than low, worthy of nothing but scorn and punishment. My belly was churning, I felt sick, choked and sweaty. "This is how it feels," I thought to myself. "This is what it's like to be Sarah. To be sentenced to an on-going pervasive attack of a merciless, superior judge who is out there to count her sins and prove her guilty of being unworthy of belonging to the human race. No wonder she is propelled to tear her own flesh, this is unbearable!"

"You do not deserve to be hurt again; you should never have been hurt in the first place," I said. "I am a bad naughty girl" Sarah replied in that same little voice. "I am bad, bad, bad!" She was clearly regressed, dissociated, speaking from within the abusive scenario and its long-lasting impact on her self-image. A huge wave of compassion and love arose in me as I held her tightly in my arms. I wanted to help her, to look after her and heal those deep, paralysing wounds. "No, you're not," I said. "The people who abused you are bad; *they* should be punished, not you!" I felt angry and protective. I was going to fight for this little girl, I was not going to let the abusers win her soul! Sarah was sobbing now, leaning against me. I rocked her in my arms and stroked her hair. The energy in the room had changed; we were cocooned together in a soft, tender womb-like space. "I wish you were my mother," she said. "If I had a mother like you, she would not let them do that horrible stuff to me." Indeed, I felt like a mother; a loving, protective, nourishing mother. My body felt warm and expansive, my breath was synchronised with hers. Having no child of my own, I was overcome with a deep, primal need to breast-feed her, drawn into her gaze, love her, make her mine, forever my child. I could hear the sweet hum of a familiar lullaby rising within me, a lullaby my mother used to sing to me when I was upset or frightened. My own mother and her way of mothering me was filling the room, as my urge to mother this wounded child intensified in me.

"I will do anything for you," I could hear myself thinking. "I will protect you and heal you and make up for all the atrocities you suffered." I did not say a word; I just watched my impinging impulses to become the saviour, the protector, the loving mother she never had. I felt powerful and strong, larger than life. I was not just a good mother with her wounded child in her arms; I was bigger than that. I was *the* archetypal good mother, the one that Sarah longed for through all those dark, scary years of her childhood and, as was becoming clear to me, was still longing for now. From early on in our work together, she constructed me as a compensatory object to her own mother, who was distanced, hysterical, self-centred and unable to bear the Oedipal competition with her daughter. Sarah was forever recruiting teachers, therapists, and mental health workers to play the role of that fantasy figure in her life. My feelings of power, omnipotence and total dedication as I held her in my arms told me of what was missing so badly in her life and of the fantasy she created in order to survive the unbearable pain of neglect and absence she had to cope with. "It was so difficult for you to go through all this on your own," I said. "You constantly longed for your mother to protect and save you. But she was not there. You survived on your own, and this in itself is amazing, don't you think?" Sarah was whimpering quietly. "You have survived," I affirmed again. "But you are forever waiting for your mother to come and take you in her arms and make it all alright. It seems to me that the pain of these longings is sometimes more excruciating than the pain and horror of the abuse." Sarah nodded silently. I was still holding her in my arms but the quality of our embrace was different. No longer the idealised, bigger-than-life maternal figure, I shrank to my human size and she, no longer a victim-child, was able to think and relate to the core of her ever-present pain. Silently, sensitively, we were holding it together, vibrating between us in the quiet room, the absence of early mothering, the unbearable pain of neglect, the defences and coping strategies, the fantasies and hope, the inevitable disappointments - all of these had been aspects of our shared experience in these last minutes. As we moved away from each other and were ending the session, Sarah looked at me and smiled, "I am so glad that you are my therapist," she said. "Thank you."

Indeed, this is who I was, after being temporarily her humiliating denigrating judge, my own never-satisfied judge, the hopeless victim, her omnipotent rescuer-mother, my good-enough mother's daughter, I was now her therapist again, the person who is called to hold and bear all these fragments of her story and mine. These were by no means the only fragments I was called to

experience and hold for Sarah, However, I will now explore some aspects of this vignette in an attempt to illustrate my understanding of relational Body Psychotherapy.

Discussion

I invite you now to imagine the scenario with which the vignette opens: I am kneeling behind Sarah and am restraining her in my arms, stopping her from following her impulse to bang her head against the wall. What are the feelings rising up in you when you imagine that moment? What is happening now in your own body? Please pay attention to your body-mind reactions as we explore that scene further. Who was I at that moment? The saviour? The protector? The idealised absent-and-longed-for-mother who takes care of her child? Yes, I partly felt all that. But I also felt like a physically strong adult who is overpowering a little girl and forcing her to obey, imposing my will on her. The abusive scenario and its impact was resonating between us in more than one way, echoing on many levels of our interaction.

As therapists, how can we orient ourselves and what can we hold onto in these scary, confusing moments of intense re-enactment?

One of the ways that I have found helpful in thinking about trauma is to conceptualise it as an external event that had been internalised and now continues as an internal dynamic. This idea of internalisation has been formulated most clearly in the traditions of Object Relations and Relational Psychoanalysis. However, many other approaches have used a variety of terms to describe the same phenomenon, among them self-state, internal(ised) objects, internal parts, ego-states or part-selves. Fairbairn (1943) talks about the impact of the internalised bad parental objects. "He (the client) is internalising objects which have wielded power over him in the external world and these objects retain their prestige for power over him in the inner world … He is possessed by them, as by evil spirits" (p. 67). Sarah's internalised abuser was compelling her to act out the abuse against her own body (Farber 2000). As with her previous suicide attempts, her ongoing self-harm and bulimia, she was now compelled to hurt herself physically in the room with me, to draw me into the ongoing battle between the abuser and the abused. As Farber (2008) puts it, "In every act of self-harm there is more than one participant and more than one self-state. There is the dissociated part of the self being abused, and then shifting abruptly and without awareness, there is the dissociated part doing the abusing. Dissociation makes possible the extraordinary feat of being both predator and prey, sadist and masochist, all at the same time." (P.26) In her excellent book 'Treating the Adult Survivor of Childhood Sexual Abuse', Messler-Davies (1994) states, "The adult survivor, in essence, lives the original abusive experience on a continuing basis every day of her life, remaining at least in part absorbed with the cast of characters around whom the abused child's internalized system of self and object representation was organized and split off in dissociated form." (p. 137)

In acting out her primal abusive scenario in the room with me, Sarah called on me to be more than a witness or a container; I was called to participate, to experience, to join in her world of dissociated part-selves. As I was restraining Sarah in my arms, I could not escape the sense of feeling like the abuser, physically forcing the little girl to obey my knowing-better will, almost saying, as he would have done, "There, there ... be a good girl and do what I say." In this way, I could force her to do what I wanted, and I knew it. She was deeply attached to me, vulnerable and dependent on me, she was going to obey me, maybe with some fight, but I was going to win. Knowing this, turned our struggle into a somewhat stimulating, even arousing, game. Then, "shifting abruptly and without awareness" - to use Farber's words - I felt like the victim, frightened in the presence of the violent, cruel and destructive force which I was desperately trying to control. I might have looked and sounded mature and composed, but this was *not* how I felt inside. I felt helpless, at the mercy of a force much stronger than me. The impulse to give up and to split off, was overwhelming. There was a strong temptation in me to say: "This is too much, I can not cope, I do not want to be here, I do not ever want to feel this helplessness again." This gave me an immediate, embodied experience of both Sarah's torture, as well as her survival strategy.

So, within minutes I had shifted between all three poles of the 'drama/victim triangle' (Karpman 1968) from Abuser to Victim and then to Rescuer, shifts that had occurred without me actively initiating any of them.

Amongst these three positions, the Rescuer pole is certainly the most attractive pole for the therapist to inhabit, and the narcissistic gratification it holds has tempted many therapists to formulate their role – and the whole task of therapy itself - exclusively from this perspective. There

is no doubt in my mind that at times I am called to embody the Rescuer pole of the triangle and that it is essential for the process that I actively want to provide this. However, as much as it is tempting to emphasise this pole at the expense of the other two, I have come to think that I need to be available to embody all three of them at different times, that all of them are - and need to be - constellated in the room (Soth 2006).
It is often the third pole - the Abuser - that is most difficult for us as therapists to contemplate, and where the line between re-enactment and re-traumatisation is most challenging. Messler-Davies (1994) explains, "The therapeutic relationship is 'where the action is'. It is the arena in which the abuse, neglect and idealized salvation are re-experienced and in which therapist and patient participate in the emergence, identification and working-through of powerful, often chaotic, transference and counter-transference paradigms." (p.5).
In working with survivors of complex trauma (Heitzler 2009) we cannot remain a neutral observer, a form of objective doctor, nor can we remain simply and exclusively a reparative parent. We are called right in, into 'the eye of the storm', to participate, survive and hold the re-enactment of what was before an unbearable life-threatening reality. The client's unconscious hope as she descends into the re-enactment is that this time the trauma can be survived by her and the therapist in a new life-affirming way. The hope is that all part-selves and split-off fragments of experience can be re-lived, met and integrated into a whole and robust Self, and that the trauma, once survived in its fullness by the therapeutic dyad, can be integrated and stored in the 'past file' (Rothschild 2000 p.28) of the memory cabinet.
Simultaneously, whilst this is happening, or precisely because this is finally allowed to happen, the therapeutic relationship forms the consistent holding environment (Winnicott, 1960a), where the client can explore a new model of intimate relationship, in which she is viewed and experiences herself - with all her beauties and flaws - as a subject in her own right - a worthy human being. This, hopefully, can be internalised and can support a new emerging sense of Self, as well as the ability to create healthy external relationships.
Therapy, is therefore "a constant volleying between regressive re-enactment and interpretation of that which is revived through the transference-counter-transference constellations that emerge, and the progressive unfolding of a new object relationship that takes place between patient and therapist." (Messler-Davies p.4).

This model poses an important question regarding the difference between re-enactment and re-traumatisation, and whether there is a difference at all. My own answer to this lies with the potential of the therapeutic relationship to contain and process the re-enactment in a way that enables the client to develop a new relationship to the traumatised self. Both re-traumatisation and re-enactment can happen spontaneously and be experienced by client and therapist as a terrifying, out-of-control acting-out. However, I see re-enactment as more than a meaningless repetition of the traumatic scenario. As the therapist is able to tolerate and regulate within herself states of hyper-arousal, dissociation, splitting and despair, her energetic presence provides the container in which the trauma can be processed and survived. The therapeutic relationship, in which the therapist does not shy away from any aspect of the trauma and is willing to enter the unbearable together with her client, stands as a stark contrast to the fundamental 'aloneness' that characterises traumatic experiences. It provides a hope and a model of surviving the trauma in a completely new way. Moreover, the therapist's ability to fully engage with the re-enactment and then to "disengage sufficiently to observe, contain and process with the patient what has occurred between them" (Messler-Davies p.4) creates the space for reflection, integration and 'meaning-making,' re-vitalising all those processes of mentalisation that were distorted during the original scenario.

Summary: Re-Enactment
To summarise, I see three main therapeutic functions of re-enactment in trauma work:
1. The client can externalise and share what she carries as a consistent internal reality, not only through words, which often are unavailable, but via other, more immediate and primal means of communication. It is well-known, according to scientific research, that the cortex and the left side of the brain are largely unable to function during and after the traumatic event (Heitzler 2009). Thus mentalisation and verbal processes are impaired and often completely blocked. This leaves the immediacy of the body and the interpersonal re-enactment of the trauma as the main channels for connecting with internal and external reality. Therapeutic approaches which rely

exclusively on language and the mind's reflective capacity will, therefore, tend to view these kinds of non-verbal communications and enactments as 'acting out'. But from an embodied-relational perspective, I consider the 'felt sense' within the re-enactment as the essential realm in which client and therapist can communicate, express and work through layers of the traumatised psyche that are not available otherwise.

2. When the client senses that the therapist is willing to engage fully with all aspects of the trauma and its impact, she feels contained and fully met. She no longer has to protect the Other from the horror and intensity of her past story, her present life , herself. She is no longer alone with it. A new model of relating, based on trust, respect and love begins to develop both internally and externally. The therapist's ability to be *in* the scenario and then to step back and reflect on it enables the working-through and processing of dysfunctional, trauma-based relational patterns.
3. As the therapeutic couple survives the full impact of the trauma on each of them individually and on their relationship, the client is able to verbalise, symbolise and find meaning in a way that was not possible before. The trauma can then be integrated in a healthy way and does not continue to form the main organising principle in the client's psyche.

In order to explore another function of re-enactment and its impact on the therapist's role, I will outline a second vignette from my work with Sarah.

Case Vignette 2

Sarah and I were sitting together in a corner in my consulting room, surrounded by soft walls. Earlier on in the session Sarah had wanted to hide and I had invited her to build a hiding place for herself in the room and hide there. She had built a small cave-like enclosure, using most of the cushions I have in my therapy room and later on asked me to join her in her hiding place. It was six months since we had begun our work together, I was getting to know Sarah and she was testing me, as a way of getting to know me. I was flattered by the invitation to share with her the safe place she had created and felt that this was a sign that we were 'making progress'. Sarah had been struggling for some time to tell me about the sexual abuse she had experienced. She did not remember anything coherent, only fragments of body-parts, snap-shots of herself in different positions, words and part-sentences that kept ringing in her ears and a sharp, constant pain in her lower belly. Sometimes she was sure that she had been abused and felt very young as she re-experienced it alone in her bed at nights. Sometimes it felt like a dream. Her flashbacks were clear and depicted an ongoing brutal, sadistic, life-threatening abuse by more than one man. But what if she was making it up, she wondered ? What if these were just her own mad fantasies?

I also had my doubts. I was aware of Sarah's early developmental wound and its prevailing impact. I knew by then how unloved and unlovable she felt, especially after the birth of her younger brother. He had been born with severe brain damage when Sarah was only two years old. The mother, who was struggling to fulfil her parental role with her little daughter, was tending to her disabled baby-boy with fierce determination. Sarah watched as her mother held her brother, sang to him and fed him, and she tried to be a good girl, with the hope of earning some morsels of affection. But those were very rare; hardly anything was left for the healthy, quiet little girl. Perhaps, I thought, she had learned that only the wounded and the sick received love and affection, so she needed to create a disability similar to her brother's? Or, to put it bluntly in the words of one of her previous mental-health carers: "She is chronically attention-seeking and like all borderline personalities, she creates a drama so she can get it."

But the flashbacks, the anxiety attacks, the suicide attempts and severe eating disorder had been consistent since she was 15. Surely they were there for a reason? Her acupuncturist, with whom I kept regular contact, informed me that Sarah's pelvis and thighs were completely blocked and there was an underlying current of fear creating severe imbalance in her system. She was convinced that Sarah had been sexually abused at a young age, but I, like Sarah, swayed between knowing it to be true and disbelieving the shreds of information we had. I looked at her, lying curled on her side, hugging one of the cushions. It was warm and cosy to hide together in her cave, made of soft fabric and colours. She was telling me about her cats and how they played together, and was now rolling on the carpet holding the cushion high above her, laughing and playing with it, like with her cat. Her

long black hair was spread around her and her green eyes shone with the pleasure of the game. Her beautiful body was alive, her breast heaving as she twisted and wriggled about. “Here,” she came closer to me, handing me the cushion, “you can hold my cat.” And she laughed, like a little girl, rolling laughter that enhanced her deep dimples. “Oh, I’d like to hold more than just your cat,” I found myself thinking. “You are so… so ... yummy!”

She gave me the cushion to hold and curled up to me, embracing me and her ‘cat’ with one arm. She was regressed, for the first time in our sessions, in a healthy way, reliving and sharing with me the one healthy relationship she had had as a young girl, the love of her cat, which enabled her to do what children do - play. And me? I was bewitched and bewildered. I could barely contain myself. The combination of the young, innocent, playful girl with the mature, beautiful body of a woman had become painfully stimulating. I looked at her full, red lips and imagined what it might feel like to kiss them. I looked at her long, tender neck and dreamt of stroking it with one finger all the way down to her collar bones and then down to … . Sarah was talking, and I pulled myself together. I must listen to her, I must STOP THIS! What IS GOING ON? Have I gone MAD? But it was really hard to concentrate on her words. I managed to respond and heard her telling me of other happy childhood memories, but I was just barely holding on to the façade of ‘the therapist’. My desire for this child-woman grew and I had a vivid image of sexual intercourse, quite passionate and, actually, also quite brutal. As I surrendered to the stream of violent sexual fantasies, I could feel a cold and cruel kind of laughter inside me, and the words “You like that, don’t you, you little tart?” shot through my mind. “You pretend to be an innocent little girl, but actually you are a sex slave!” I found myself thinking.

I was shocked, but before I could collect myself, the next thought emerged, now directed at myself rather than her: “You pretend to be a nice, trustworthy therapist, but actually you are a sex-maniac!” Suddenly, it all made sense. Here I was, the trustworthy adult, pretending to care and hold her, but actually getting aroused by the innocent sensuality of the young girl. Here I was, turning in my mind a playful interaction into a violent sadistic intercourse. I was the abuser; the abuser was in me. I felt horrible, disgusted with myself. How could I? What is it in me that allowed this to happen?
I had never experienced anything like this before, and however varied and colourful my own sexual fantasy-world may be, it never included brutality or aggression and was never stimulated by young children. I looked at Sarah, she seemed so young and vulnerable. She smiled at me: “I don’t know how you do it.” she said. “But I feel so much better, I feel … light, almost happy. I never feel like this! As if a weight was lifted.” “Yes,” I responded, “it was very rare that you could play like a little girl without worrying about somebody who would turn your game into something dangerous, violent, sexual.” “You believe me then!” she cried. “I knew it! You do believe me!” She hugged me tightly, relieved and grateful and I hugged her back. Nothing of those overwhelming feelings was present in me now, I was grounded in my own body again, feeling tired, washed out after this violent encounter. I knew now without a doubt that the abuse *did* happen, I had met the abuser, met him *within* me, and I had survived.

Discussion

It is now common knowledge that dissociation is a central coping mechanism during and after trauma. Van der Kolk (1996) writes, “The very nature of a traumatic memory is to be dissociated, and to be stored initially as sensory fragments that have no linguistic components.” (p. 289). These “fragments” consist not only of the traumatic event itself, but also of “the traumatized individual’s experience and representation of self within the abusive events, and her experience and internalization of the others in her world, as they are represented at such abusive moments” (Messler-Davies p. 64). These representations of self and others are usually split-off and in extreme cases form what we call DID - Dissociative Identity Disorder. One of the goals of therapy, therefore, is to integrate those split-off self and object representations into a coherent/unitary sense of Self. Sarah was not able to tell me about her full experience of the abuser, as her memory was protecting her sanity by dissociating from it. But split-off fragments of her physical, mental and emotional encounters with him were stored in her body-mind.
Understandably, like other victims of childhood trauma, Sarah had no way to verbalise this complex internal organisation, so her way of communicating it to me was via projective identification.

Projective identification is a term first coined by M. Klein (1946) to describe a defence against an intolerable, painful or dangerous idea or belief about the self that the projecting person cannot accept.
Segal (1974 p. 27-28) writes, "In projective identification, parts of the self and internal objects are split off and projected into the external object, which then becomes possessed by, controlled and identified with the projected parts." Messler-Davies describes in detail the way in which this process occurs: "First, the patient projects a split-off internalized self representation onto the therapist to control good or bad aspects of the internal world. Second, the clinician identifies with the projected aspects of the patient's self, subjectively experiencing himself in a way that is ego-alien but perfectly congruent with the projected contents." (p.161).

Projective identification plays an important role in re-enacting the original abusive scenario in the therapy room. This time, the re-enactment happened *within* me, in my own body-mind and remained contained as such. I did feel the abuser, I identified with and embodied him and his impulses and thoughts, but I did not act them out. Via this non-verbal, unconscious form of communication, I gained an important piece of information that was not yet fully available to Sarah herself. More than confirming that some form of sexual abuse had taken place, I gained first-hand intimate access to the abuser's impulses and motivations. I learnt how he was sexually aroused by the child's innocence and playfulness, and how he had to twist precisely that and turn her into 'a slut' which he could then terrorise and humiliate.

This gave me more than an understanding of the abusive scenario; it made me feel the chill of his psychopathic presence in my own bones. I now knew about the abuse in a way no words could describe. I believe that it was this first-hand knowing that allowed Sarah to feel that I believed her. I also believe that those moments, in which I was the abuser and carried him within my system, allowed Sarah to feel lighter and more hopeful at the end of the session. I carried him *for* her, and somehow she sensed that she no longer had to carry him alone. More than the insight into first-hand unconscious information, I see projective identification and re-enactment as a call to the therapist to experience, contain and hold self-parts that the client is not yet ready to integrate into consciousness.
An important aspect of the regulatory function of the therapeutic relationship is the therapist's capacity to integrate and contain within herself what her client is not yet able to bear. In this, the therapist is more than a mere witness or an agent of support; she is the psychic container in which all fragments of the trauma can gradually come into consciousness.

The body

Having addressed the relational aspect of my therapeutic model, I would like to consider my understanding of the role of the body in working with trauma. The current discoveries in neuroscience confirm and explain a key principle in Body Psychotherapy, already intuited and expressed by Reich in the 1930's - that body and mind are one. Our recent attempts to formulate this systemic understanding of the body-mind as a complex whole is reflected in phrases like 'embodied mind' or the 'thinking body.' But what do we mean by this? And how does it actually manifest in practice ?

Much has been written in recent trauma literature on the traumatised body. Schore, Van der Kolk, Herman, Ogden and Damasio have been voicing, from different perspectives, a singular truth: "The body keeps the score." (Van der Kolk 1994). They all strongly believe that the therapeutic journey towards resolving the traumatic wound should be based on working with the body as the body is the carrier of the trauma and its symptoms, as well as its best hope for healing and recovery. As Farber puts it: "Infant trauma occurs before the child has the use of language to create narrative memory, and in later trauma the experience may be dissociated. But in either scenario the experience is stored in the body as a somatic memory. That is, the body comes to know what the mind does not remember" (2008 p.30).

I have written elsewhere (Heitzler 2009) about my integration of various trauma therapy approaches, including EMDR and Body Psychotherapy methods in working with complex PTSD, which include, amongst others, the resolution of incomplete cycles, especially ways of releasing the blocked fight-

or-flight response through expressive movements and voice. I will not expand further on this now as I wish to focus on an angle less widely addressed so far: the therapist's body.

In every therapeutic encounter, there are "two bodies in the room" (Catherine Baker-Pitts 2007). These bodies interact, exchange non-verbal messages, regulate and impact each other. As much as I do not wish to exclude the client's somatic experience from my therapeutic frame of reference, I see no good reason to exclude my own.

As illustrated in the earlier case material, I used my own body as a guide in the minefield of unconscious processes that constellated between Sarah and me. By tuning into my own somatic counter-transference, I could experience Sarah's split-off part-selves in my own body, thus gaining a first-hand understanding of the internalised relational matrix.

I also referred earlier to my body as a container, able to hold the fullness of the unbearable experience, whilst the client is struggling to integrate the overwhelming impact into consciousness. In order to qualify as a safe container for both the client and the trauma, it is my embodied presence that is needed to survive the test of trust.

"The client's experience of the therapist as the safe containing object is measured not by verbal cognitive exchange between them, but by the client's energetic perception of the therapist's embodied presence and the sense of congruence between the therapist's verbal and energetic messages" (Heitzler 2009 p.181).

One of the main capacities damaged during trauma is the capacity for self-regulation (Carroll 2009); the ability to recover emotional and physical equilibrium after being knocked off balance by the traumatic event and its impact. Most people who suffer childhood trauma are struggling to regulate themselves and spend their lives oscillating between bouts of hyper-arousal and deep debilitating depression. Self-harm, bulimia and self-medication are some of the tactics by which they attempt to get relief and gain control over their overwhelming inner chaos. The ability to regulate our emotions develops in infancy via mother-baby interactions. The mother functions as the regulatory object through the use of her body, her voice, her gaze, and her energetic presence. Later on, through the use of a 'transitional object' (Winnicott 1953) the child can learn to regulate herself. Contemporary attachment theory views mother and baby as a "mutually regulating system" (Carroll p.97) in which the two participants mutually affect and regulate each other, creating, through the dyad, a system and an entity larger than the two, also known as 'the third'. This idea refers to the relationship itself as an entity, with its own personality, needs and capacities. One of the capacities of this 'third' is the ability to lose the system's homeostasis and to strive to gain it again, in rupture-and-repair cycles, giving the system a quality of robustness and resilience. For people who did not experience the healthy symbiosis with Mother, the task of self-regulating through their own body is almost impossible. As they do not have in their body the experience of being soothed by Mother, they cannot internalise the comforting Other and may often turn towards a harsh, persecutory transitional object, re-creating the sense of abuse and pain (Farber 2008).

In therapy, Sarah often expressed how 'dead' or 'numb' she felt, how 'unreal' the world around her was. Splitting off from her body, involuntarily dissociating from it, led to a disembodied sense of the world and herself inside it. Lacking the capacity to regulate her intense feelings, she turned to me, asking to be held. Using my body as the transitional object, she was able to regulate her breathing, get a sense of her own skin, get back into her body. Safely cocooned in my embrace, she was able to share what she could never put into words before; the most terrifying, shameful moments of the sadistic abuse, her own hatred of herself, her regressed longing for the ideal mother. The sense of my empathic resonance transmitted through my own flesh, literally touched her in some primal layers of her experience where she had never been touched before, and she was able, for the first time, to surrender. I strongly believe that this level of pre-verbal, animal-like experience of safety and holding could only happen through our mutual embrace. In my mind, there is no replacement for this embodied level of transforming the traumatic experience of touch as invasive and abusive into a containing, respecting, life-affirming exchange between two people.

As may have become explicit, I do place great emphasis on the reparative aspect of therapy, especially when it comes to pre-verbal layers of working with the body. However, lovely reparative experiences, as real and moving as they were, were not the only interaction we experienced through our bodies. Often, this unambiguous, down-to-the-bone sense of my love evoked in Sarah waves of

primitive hate and rage, which were challenging for us both, especially as she would turn those feelings against herself. My role as the regulatory object expanded during those moments as I was called on to regulate the internalised abuser, as well as the victim. That part-self also demanded a visceral interaction with me, as the container and regulator for the sadistic impulses to humiliate and torture. These experiences of the dark side of intimacy, bordering on the edge of psychotic disintegration, were hugely demanding and often draining for me.

Intensified by our physical proximity, there were other moments when Sarah's wound would evoke my own developmental pain. There was nowhere to hide, nowhere to run to. Those moments created a different kind of intimacy, perhaps more tender, but nonetheless provoking and demanding.
What does an ordinary human being, a therapist, need in order to survive, contain and function therapeutically when the process takes us to and across these edges? What will enable us to work "at the edge of the window of tolerance" (Heitzler 2009 p.192 note 1) of ourselves as well as that of our clients? For me, the answer lies in the necessity to stay grounded in my own body, monitor my somatic counter-transference and access my own self-regulation capacities. As Carroll puts it: "If this (i.e. the therapist's) self-regulation is there, then the therapist can also allow herself to be knocked off balance, controlled or confused in the process with the client. At times her job may be to survive the intensity of her own and the client's feelings, staying with the process and with the client at the border between chaos and order" (Carroll 2009 p.102).

It is through my own process, first as a client, then as a trainee in an experiential Body Psychotherapy training and later as a therapist, teacher and supervisor, that I was able to work through layers of denial, resistance and pain dormant in my own body-mind. It is through my personal journey that I have gained the first-hand insight to madness and despair as a visceral, somatic, moment-to-moment experience. As my body learned a new language of vulnerability and trust, I was able to literally lean on my therapist and surrender to those feelings and experiences which it was - for so many years - my second nature to suppress. It is in daring to go to those scary, dark edges that I have learned to trust the nature of the healing process, the innate capacity of the body to transform darkness into light. Anchored in my own relationship with my body I can offer my embodied presence as a therapist. It is this embodied presence, I believe, that enabled Sarah and myself to lose the safe ground under our feet, to travel together to hell and back and to grow.

Summary

Working relationally with trauma in an embodied way, we, therapists, are called to walk into the fire. We cannot stay outside, gazing with horror, shouting warning, offering advice and instructions. This will not do. We need to step in and feel the fire in our own bodies and souls, be consumed, destroyed and revived. It is only by daring to embrace the trauma in our own embodied experience that we can survive it. It is only by being shaken to our core that we can truly find hope. I believe that by engaging and surviving on these levels within ourselves, we help our clients in finding their own hope and salvation.

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