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Descending Into and Out of the Maelstrom: Soma and the Survival Struggle

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Soma and the Survival Struggle

by

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Abstract

The purpose of this qualitative phenomenological study is to highlight the ways "surviving therapists" adapt to the inner-spaces in which they are still affected by their traumas. Surviving therapists are defined as therapists who identify as having experienced a trauma caused by another human being while maintaining an observational stance in relation to their body and self-experience. Therapists are not immune to the lasting effects of trauma: they may experience somatic reactivity and painful affective states in working with trauma patients. As surviving therapists have experienced events they may unconsciously choose to keep out of awareness, they may rely on adaptations in the face of regression, repression, and dissociation. A phenomenological method using a grounded theory approach was used to explore and document the ways surviving therapists utilize somatic sensations in their work. Edgar Allen Poe's "A Descent into the Maelstrom" is used as a device to mirror participants' processes of using metaphor to bridge the gap of symbolized and unsymbolized clinical experiences. Themes that arose from interview data included regulation style, regulation as cue, identity, metaphor of the journey, aggression/protection, and the sweet humor of life. Participants detailed the ways in which they used bodily sensations as cues to unconscious processes occurring interactively in the room or simply within and highlighted interventions based on these cues. Themes derived from this study can be used to generate strategies of training, supervision, and personal reflection to aid in the continued struggle for surviving therapists to survive.

Keywords: surviving therapists, trauma, bodily sensations, adaptions

Descending Into and Out of the Maelstrom: Soma and the Survival Struggle

Chapter 1

A survey of 250 male and 250 female clinical and counseling psychologists found that 69.93% of women and 32.85% of men had been exposed to some sort of physical or sexual abuse during their lifetime (Pope & Feldmen-Summers, 1992). One third of male psychologists and two-thirds of female psychologists reported at least one episode of violence inflicted on them in their histories (Pope & Feldman-Summers, 1992). Collectively, little is known of the abuse histories of clinical and counseling psychologists, although many have reasoned that these histories may be a motivating factor in working with others who share an abuse history or in an ability to work effectively with a trauma population. One third of therapists who identified as having experienced trauma acknowledged remembering a traumatic event for the first time while conducting therapy (Pope & Feldman-Summers, 1992). Dissociation, repression, and pre-verbal trauma make it difficult to categorize accurately the collective experienced traumas of a lifetime. Furthermore, while it is evident that a significant proportion of participants had experienced abuse or violence in their lifetime, it is difficult to determine whether this was a reflection of the percentage of abuse and violence in the general population due to issues of scope, procedures, and/or content of the study differing from prior studies. It is clear; however, that many therapists have trauma in their background—and that working with trauma can bring one's own trauma into awareness.

While therapists are encouraged to "know thyself" in terms of their own past and its influence upon their patients, this may be difficult when countertransference is of a pre-verbal/non-verbal nature and is experienced primarily as sensation. It may be that the process of imagination and metaphor allows surviving therapists to transcend their own histories when

working with sensation and reactivity, as it may allow for integration of what was previously defended against. This phenomenological study used a grounded theory approach to explore the accommodations surviving therapists use in dealing with trauma-associated countertransference, documenting the ways in which surviving therapists experience and use countertransference that is experienced through a non-verbal channel in their work with patients who have experienced trauma. Three licensed psychologists were interviewed for this study. All identified as having experienced personal trauma caused by another human being; one in childhood, one as an adult, and one declined to disclose the time their trauma occurred. The two participants who chose to disclose their trauma had experienced discrete event traumas that they associated to other traumas occurring in early life.

Themes generated from this study provide indications for training, supervision, and reflection to aid surviving therapists in working with their trauma-associated reactions.

Surviving

The term "Survivor" has been used extensively in the literature to define a person who has experienced personal trauma (Frawley & Davies, 1994; Herman, 1992; Ogden, 2006). "Victim" is less commonly used—associated with helplessness, fear, and vulnerability. Survivor implies strength and an end-state of having overcome the trauma. And, yet, both terms imply a static state/identity that does not represent the complexity of what it means to have experienced trauma; people are left changed and they will not forget their experiences of helplessness and fear. In working with trauma patients, surviving therapists will find themselves re-experiencing states associated with victimhood and the experience of helplessness will prove a difficult remembrance. Therapists with trauma histories will have parts of themselves that survived, parts that struggle to survive, and parts that did not survive. They will carry some sense of what it is

like to be a victim or survivor, although this may not make up the entirety of their identity or self. In the service of readability*, surviving therapists* refers to therapists who have trauma in their background and, thus, have different self-states associated with trauma. Surviving implies process (not end-state) and struggle. Winnicott (1974) writes that in order to relate to others as separate from themselves, certain patients must engage in a process of feeling as if they are destroying the therapist and that the therapist is surviving the attacks. He writes that change depends on:

> The analyst's survivial of the attacks, which involves and includes the idea of a quality change towards retaliation. These attacks may be very difficult for the analyst to stand, especially when they are expressed in terms of delusion, or through manipulation which actually makes the analyst do things which are technically bad. (p. 123)

Surviving includes the therapist's reliability and refraint from retaliation (Winnicott, 1974). Thus, therapists with trauma histories may struggle to survive their patients' attacks, as these attacks will call up remembrances and self-states of helplessness and victimhood. This study explored the ongoing struggle to survive that therapists with trauma histories engage in as they attempt to contain their patients' traumatic material while grappling with their own.

Containment. Bollas (1992) describes the

> psychoanalyst's capacity to follow internal sensings when listening to patient's material, such feelings are responsive to the subtle exercise of forms of experience and modes of expression in the analysand. Patient and analyst develop between them internal objects specific to the mutual processing of the self (analyst or patient) with this other (analyst or patient) in this particular place (the psychoanalysis). Just as a ship is constructed for sailors to sail the seas, or instruments are crafted in order to play music, patient and

analyst construct internal objects to process the analysis. (p. 92)

Bion's (1962) conceptualization of "containment" (p. 90) concerns the therapist's ability to receive and process unconscious communication from the patient that awakens self-states in the therapist. By calling upon their own subjectivity, therapists are able to understand something of the patient's internal world which cannot yet be communicated consciously/verbally. Bollas (1992) describes the use of "spirits" or internalized others that arise in the therapist in reaction to the patient's spirits, another aspect of intersubjectivity and unconscious communication (p. 65). As the patient may unconsciously place the therapist in the role of victim, bystander, or perpetrator, these may be the corresponding spirits that will be awakened in the therapist (Wilson & Lindy, 1994).

In associating to the participant's material, Poe's short story *A Descent into the Maelstrom* came to the researcher's mind. It is used throughout the text for two purposes. One is the honoring of the data as coming not solely from the unconscious of the interviewer, but in relation to the unconscious of the participant. *A Descent into the Maelstrom* is an apt device as it is a story-within-a-story, paralleling the therapist's subjectivity and personal history in relation to the patient's. Thus, the clinical story-within-a-story concerns the therapist's ability to receive and contain bits of the patient's story that cannot yet be integrated, calling upon their own histories and self-representations to allow an understanding to enfold. The other function of *A Descent into the Maelstrom* is to language some of what was unconsciously communicated in metaphor form, tuning in to data that would not be apparent in the text alone.

Trauma spirits. Bollas (1992) finds himself "inhabited, then, by inner structures that can be felt whenever their name is evoked; and in turn, I am also filled with the ghosts of others who have affected me" (p. 58). All characters did not survive in Poe's story; they are all considered to

be internal self-representations that may form as a result of trauma. As co-constructed representation is necessary for trauma to be remembered and integrated instead of re-experienced (often in the form of bodily sensation), the story is used as a leitmotif throughout—an overarching metaphor among many other stories that make up the current study (Bollas, 1992; Ogden & Pain, 2006).

In *A Descent into the Maelstrom*, the narrator is taken on a journey to a cliff by a fisherman who had survived a mythic maelstrom, or whirlpool. The reader does not know why the fisherman/survivor has taken the narrator to get a glimpse of the site of his trauma on a cliff that overlooks the ocean. The survivor explains that it was:

> 'Not long ago,' said he at length, 'and I could have guided you on this route as well as youngest of my sons; but, about three years past, there happened to me an event such as never happened before to mortal man—or, at least, such as no man ever survived to tell of—and the six hours of deadly terror which I then endured have broken me up body and soul. You suppose me a very old man—but I am not. It took less than a single day to change these hairs from a jetty black to white, to weaken my limbs, and to unstring my nerves, so that I tremble at the least exertion, and am frightened at a shadow. Do you know I can scarcely look over this little cliff without getting giddy? (Poe, 1998, p. 26)

Surviving therapists will experience states of helplessness in their work with trauma. Within *A Descent into the Maelstrom* there are five main characters: (a) the traumatized survivor whose hair has turned white; (b) the narrator and witness to the story; (c) the maelstrom, a great swirling representation of trauma; (d) a brother who drowned; and (e) another brother who went mad. In this study, the term "surviving therapist" is used to connote a therapist who lived through a trauma and continues to make the journey back to the maelstrom in their work with trauma

patients. It is never directly addressed in the story why both parties have chosen to go back to the site of the survivor's trauma; however, Janet (1925/1976) recognized that trauma is an experience of helplessness-and one attempts to master helplessness by attempting to regain a sense of efficacy.

Surviving therapist. The term *surviving therapist* is used to denote a therapist who has within them internal representations, or objects, reminiscent of the survivor, the witness, the drowned and mad, and the maelstrom within them. Although individuals will have a personal coloring and idiom to each of these representations, trauma leaves its own characteristic mark. Because the context of psychotherapy sits within the complexities of a human relationship, participants were selected based on having experienced a trauma caused by another human being.

Inherently, surviving therapists will have some notion of what it is like to feel overwhelmed and helpless in connection to another person's actions and will have some internal representations, or objects/spirits, that can be activated by certain stimuli. Despite having experienced such trauma, a surviving therapist is defined as someone who struggles to deal with their trauma associated countertransference, and attempts to "survive" as a therapist by accepting, tolerating, and making sense of their trauma-related reactions and to the patient's transferences. As Harris (2006) notes, "there are ghosts and wounds that are quite fresh and accessible no matter how thoroughly worked out, and there is the resilience of mastery, of the turn to work, of the resolve to be of help" (p. 543). Traumatized therapists will have ghosts and wounds that will beg for healing before they may survive in their role as therapist. However, even when trauma has been symbolized and worked through in treatment, old wounds will inevitably reopen and be re-experienced often in somatic and non-verbal ways.

Through embodiment, surviving therapists can have access to their sensation and subjectivity so that they may recognize it and utilize it in their clinical work. As trauma is often re-experienced in the form of bodily sensation (Ogden, 2006) trauma-associated spirits may take form in the bodily arena. However, the survivor therapist's connection with their body may be the site in which they experience difficult trauma-associated countertransference, making embodiment a process that is struggled with rather than attained.

At times, the therapist may not survive in their role as therapist—and their patients may incur damage. For instance, in a study of 17 therapists involved in sexual misconduct with patients, the most common finding was the tendency "in their work with many patients to be intolerant of the negative transference" (Plakun, 1999, p. 285). Therapists, as a result of their own traumatic histories, can find it difficult to be perceived as abusers by patients and reject the transference, causing a failure to survive in the Winnicotian sense (Plakun, 1999).

Countertransference, Trauma, and the Body

Freud (1933/1966) defined birth trauma and all later traumatic moments as the experience of having been overwhelmed by sensation and having no way to master it. Resulting traumatic anxiety is a fear of a re-experiencing this moment of too-much. Later discrete traumatic events disrupt the course of development and cause damage. The discrete traumatic event is a moment of too-much and surviving therapists working with trauma will, at times, feel as if they are steering close to this moment in their countertranferential reactions.

Anderson (2007) adds that no matter how a therapist comes to understand countertransference as a concept, the therapist's countertransference is both critical to the therapy and at the same time never able to be completely mastered. This leads to "a terrible combination: The mix of powerlessness and demand is a prescription for dissociation and

trauma. This may be one of the indissoluble, irreducible conditions of analytic work" (p. 259). Freud (1933/1966) wrote of the two outcomes of anxiety:

> Either the generation of anxiety—the repetition of the old traumatic experience—is limited to a signal, in which case the remainder of the reaction can adapt itself to the new situation of danger and can proceed with flight or defense; or the old situation can retain the upper hand and the total reaction may consist in no more than a generation of anxiety, in which case the affective state becomes paralyzing and will be inexpedient for present purposes. (p. 545)

In traumatic anxiety that can be used as a signal, the result is defense and accommodation. The therapist's construct of professional identity may not include personal defense and flight, perhaps leaving them increasingly vulnerable to anxiety that is paralyzing and unusable as a signal. This sense of surrender ushers in a traumatic response, and observational capacity is lost, the patient is lost, and the therapist's surviving is in question.

Freud (1933/1966) defined birth trauma and all later traumatic moments as the experience of having been overwhelmed by sensation and having no way to master it. Resulting traumatic anxiety is a fear of a re-experiencing this moment of too-much. In dealing with countertransferential responses, surviving therapists will feel at times that they are steering dangerously close to this moment. In traumatic anxiety that can be used as a signal, the result is defense and accommodation. A therapist may eventually be able to use such a signal to understand what is getting stirred in them, what may be going on in the room, and how this could inform the therapy. It could also result in repression, regression, and dissociation which can potentially disturb the aforementioned process.

Miller (1997) theorizes that therapists all have experienced a type of developmental

trauma which draws them to their profession. They have become masterfully "tuned in" to the other's unconscious and adapt to their unconscious needs; they are comfortable subverting their own needs to orbit around another person. Others have noted precocious caretaking as a commonality in therapist histories (Harris, 2006). Not being able to soothe the patient, being unable to master one's own mounting anxiety, and feeling as if one is unable to care for the other may give rise to anxiety related to an early sense that one's survival is dependent on successful care of the other. This type of trauma affects how later traumas will be structured and experienced. It also predisposes therapists to meet their own needs through their patients if not worked through. For Miller, working through entails gaining:

> lost integrity by choosing to look more closely at the knowledge that is stored inside our bodies and bringing knowledge closer to awareness. This path, although certainly not easy, is the only route by which we can at last leave behind the cruel, invisible prison of our childhood. We become free by transforming ourselves from unaware victims of the past into responsible individuals in the present, who are aware of the past and able to live with it. (p. 2)

Working Through

Miller (1997) indicates that "working through" trauma involves using the body to become more aware of repressed material, turning it into something that can be remembered instead of relived. This echoes the process of turning repressed, raw material into symbolized experience. Psychic damage and failures in caretaking result in "forms of disconnection and dissociation, both between the non-verbal and verbal systems, and, more crucially, among the multiple channels of the non-verbal modalities" (Bucci, 1997, p. 162). Furthermore, "conflicts may lead to blocking of connections with the non-verbal schemata or between nonverbal representations

and words" (Bucci, 1997, p. 163). In this lens, countertransference that is experienced solely through the somatic channel implies some possible origins. One is that some type of trauma has occurred and may have remnants of a regression to pre-verbal trauma. Countertransference experienced as purely somatic may also indicate a defensive blocking that prevents sensation from being connected to words so that the complete picture is kept from becoming conscious. Given Miller's description of the developmental trauma of the therapist, and the potentially "traumatizing" effect of countertransference, a therapist's career choice may be seen as a type of repetition-compulsion. However, Modell (1999) writes that a certain type of imagination and capacity to use metaphor enable the recontextualization of a memory. This process may facilitate a person in transcending trauma. Bucci (2002) sees this in her concept of the referential process.

The referential process connects and links systems of non-verbal information to language and to one another. It is crucial to human functioning—but it is a limited system. The "subsymbolic sensory and somatic representations can be expressed only indirectly by discreet, abstract symbols of the verbal code" (Bucci, 2002, p. 771). In attempting to describe an emotion, a taste, or perform a dance, the difficulty of putting words to subsymbolic process is evidenced. Images act as bridges between the subsymbolic and the verbal code. Poetry or literature that has the ability to evoke emotion in the reader is imagery-rich; the imagery carries aspects of the subsymbolic that resonate in the other (Bucci, 2002).

Emotional schemas contain elements of all systems. They are psychic structures built and experienced through memory, interaction, and emotion. Emotional schemas are laden with body representations and sensory experience. These make up the "affective core" that is the "constant that identifies emotional events and that clusters them in categories across varying contexts and contents. Thus, we may feel the same sort of feeling, the same emotion, the same bodily and

cognitive functions, with different people, in different times" (Bucci, 2002, p. 772). The sense of feeling a certain way with a certain type of person or having a certain bodily reaction may all point to Bollas's (1992) spirits that can be awakened and utilized in therapy. Once subsymbolic material is stimulated in therapy, it can

> play out as the operation of the referential process: activation of the subsymbolic bodily and sensory experience of the affective core in the session; associated with ongoing events in the therapeutic relationship; triggering memories of the past; leading optimally to changes in the emotional meaning of the activated imagery, and modulation of the bodily and emotional responses themselves. (Bucci, 2011, p. 52)

Both parties maintain a willingness to explore the waters of painful subsymbolic experience as spirits make their presence known (or felt). As both explore the experience and associative material, connections to the symbolic and narrative system can be made and new understanding emerges (Bucci, 2011). Bucci (2001) sees the therapist's task as:

> activating the imagery that the patient does not yet possess, to enable the referential process to proceed. Imagery is the pivot of the referential process, symbolizing contents and enabling connections to words. If the words are effective, they will evoke imagery for the patient that connects to his own somatic and sensory experience. (p. 63)

As therapist and patient work to co-construct meaning, "a kind of shared symbolization will take place; through the work of the analysis, what the patient had been unable to symbolize in the past with his or her primary objects will then be offered a second chance of being dealt with" (Roussillon, 2010, p. 1412). Both participants in the therapy are affected by the intermingling of personal histories, personalities, and psychosomatic phenomena (Ogden, 1994). In therapy with a

surviving therapist and trauma patient, both parties' trauma memories can resurface and intermingle and both parties can be affected by the process.

Modell alludes to the difference between memories that are fixed and memories that have been reworked. Traumatic memories are "wordless and static" (Herman, 1992, p. 175). They are not subject to change or development and they do not contain interpretation or emotion. One therapist described trauma memory as similar to a silent film. The purpose of therapy is to rework the memories by adding the words and music (Herman, 1992). Similarly, "there is a difference between individuals who remain open to new experience and those who remain prisoners of the past" (Modell, p. 8). Miller (1997) sees this difference as stemming from the process of using the body to become more aware of one's history. Therapists may use this imaginative capacity in their work with trauma patients, and they may rely on it to mend the split between verbal and non-verbal schemata. One therapist found that a patient "needed to test my capacity to express her affects for her until she was strong enough to feel them" (Pines, 1986, p. 298). By containing the patient's unintegrated experience and allowing it to register in their own subjective experiences, therapists can help to turn what has been previously repressed or unsymbolized into co-constructed, conscious meaning (Roussillon, 2010). This meaning can be mourned as occurring in the past, rather than
re-occurring in the form of intrusive remembering.

Unconscious material that has been repressed and never represented must be symbolically represented to become conscious (Freud, 1923/1961). This material has never been thought (symbolized) and then repressed; it was never formulated due to its disturbing contents. The patient is "obliged to *repeat* the repressed material as a contemporary experience instead of, as the physician would prefer to see, *remembering* it as something belonging to the past" (Freud,

1923/1961, p. 12). Repetition-compulsion is the intrusion of traumatic material (Freud, 1923/1961). Trauma reenactments, in which some part of the trauma is unconsciously repeated, may be an attempt at spontaneous healing or mastery (Herman, 1992). Janet (1925) recognized helplessness as the primary insult in trauma and saw actively recreating the trauma as an attempt to replace helplessness with a sense of efficacy. Surviving therapists may be prone to repetition-compulsion as they attempt to replace inevitable experiences of helplessness that arise in trauma work with feelings of self-efficacy. They may need to be able to tolerate and make use of feelings of helplessness to aid the patient in integrating their victim self-states.

In the process of working with repressed and unsymbolized material, the therapist calls upon their own subjectivity and the patient's associations to form representations of the past (Roussillon, 2010). The mind can then use these "re-presentations" to register affect, sensation, repetition, and symptoms as components of the past, and not as occurring in the present. Thus, containment, language, and metaphor are inherent in processing a patient's unconscious communication in a way that will lead to further symbolization, elaboration, and growth (Bollas, 1992). What was previously unbearable can now be pondered, communicated, felt, and tolerated. Trauma is remembered, and not re-experienced as occurring in the current moment. Trauma becomes a bearable subjective experience due to the therapist's reliance on empathy "towards what is taking place without the patient being able to give proper form to it, in order to make contact with and reconstruct, through portraying them, the subjective experiences that are involved in the pattern of the transference" (Roussillon, 2010, p. 1412).

Surviving therapists must find ways to contain trauma-related countertransference in order to make use of it. They must maintain a willingness to make contact with what is both painful for the therapist and the patient, and eventually foster the struggle towards symbolization.

The following background information provides a framework to understand trauma and its role in the struggle.

Background Information

Before reviewing the current literature on the surviving therapist and somatic countertransference, it is necessary to outline some of what is known of the history of trauma theory, the psychology of trauma, and countertransference.

The history of trauma theory. As Judith Herman (1992) notes, the study of psychological trauma has been picked up only to be dropped repeatedly, becoming an "anathema" due to its controversial nature (p. 11). Herman writes that there have been three periods in which trauma broke through to social awareness. Each period coincided with a political movement: the first being the anti-clerical movement in 19th-century France; the second being the anti-war movement; and the third being the feminist movement. She explains that dissociation and repression are also present at the social level, and without political movements that allow discourse and alliance with victims, society's proclivity towards forgetting results in massive denial. Van der Kolk, McFarlane, and Weisaeth (1996) explain this phenomenon as a consequence of society's benefit of avoiding the reality and disturbing nature of trauma.

Yet, trauma is represented in the cultural sphere. Farrell (1998) finds a preoccupation with trauma in cinema (for example, *Schindler's List*), pop-culture, and fiction. By the 1980s and 90s, "there were no 'evil empires' left to make sense of cold war sacrifices, and a growing gap between rich and poor, institutional power and everyday people, had created the grinding contradictions of the Gilded age. As the sense of disorientation spread, the idea of trauma flourished, too" (p. xiii). In a complex and disorienting world, people could:

> use trauma as an enabling fiction, an explanatory tool for managing unquiet minds in an overwhelming world. But it has explanatory power, because, however overstated or implausible the concept sounds, people feel, or are prepared to feel, whether they are aware of it or not, as if they have been traumatized (p. x).

Overwhelming experiences have long been thought to cause psychological disturbance. In the 19th century, Jean-Martin Charcot observed neurological symptoms in hysterical patients, eventually deeming them psychological. Janet and Freud furthered his work by beginning to listen to these women, instead of simply observing them (Freud, 1896/1961). Both men came to see that hysteria's symptomatic picture represented a reaction to overwhelming events. In 1896, Freud purported that hysterical cases all had something in common: they had experienced childhood sexual abuse. The idea became known as "seduction theory," and was met with serious criticism and controversy (Mitchell & Black, 1995). However, Freud reworked and refined his theory and changed the origin of hysteria from stemming from actual sexual abuse to the hysteric's sexual fantasies. He noted that:

> ...the astonishing thing that in every case...blame was laid on perverse acts by the father, and realization of the unexpected frequency of hysteria, in every case of which the same thing applied, though it was hardly credible that perverted acts against children were so general. (Freud, 1897/1985, p. 6)

Furthermore, he was faced with the:

> ...continual disappointment of my attempts to bring my analyses to a real conclusion, the running away of people who for a time had seemed my most favourably inclined patients, the lack of the complete success on which I had counted, and the possibility of explaining my partial successes in other, familiar, ways. Then there was the astonishing thing that in

> every case . . . blame was laid on perverse acts by the father, and realization of the unexpected frequency of hysteria, in every case of which the same thing applied, though it was hardly credible that perverted acts against children were so general. [Perversion would have to be immeasurably more frequent than hysteria, as the illness can only arise where the events have accumulated and one of the factors which weaken defense is present.]. (Freud, 1897/1985, p. 6)

Freud (1966/1933) defined the traumatic moment as based on birth trauma, saying that "it calls upon the mental experience a state of highly tense excitation, which is felt by unpleasure and which one is not able to master by discharging it" (p. 557). Traumatic anxiety, thus, initially arises at birth when the magnitude of unpleasure cannot be mastered. Later manifestations can occur as anxiety that signals the re-experiencing of such a moment (Freud, 1966/1933). Freud (1966/1930) noted that adult psychic trauma is initiated by "the essence and meaning of the participant's estimation of his strength...and...his admission of helplessness...in the face of the 'Erlebte Situation'" (p. 166). Krystal (1997) defines this as the

> subjective helplessness and the *surrender* to it. Once the *surrender* takes place, the affective state changes to a catatonoid reaction that has certain commonalities with cataleptic responses, which in turn have the following attributes in common with trances: the more one submits, the more one obeys orders and *feels* unable to resist or escape and the more one goes into profound surrender. This vicious circle is the initiation of the traumatic process. (p.133)

The study of trauma gained further attention when "soldier's heart" was recognized in World War I—although it was not until World War II and the Korean War that "shell shock," and "battle fatigue" started to be used as some of the first diagnostic labels (APA, 2000, p. 19).

Herbert Spiegel, a psychiatrist in the African campaign in World War II, found that soldiers developed a heightened dependency on each other in the conditions of war, and that these interpersonal relationships were preventative in the development of traumatic neuroses (1944).

The first edition of the Diagnostic and Statistical Manual (DSM) carried within it the "Gross Stress Reaction" (APA, 1952). In the next edition, the disorder was dropped from the manual. In the third edition, the disorder became an anxiety disorder: Post-Traumatic Stress Disorder (PTSD).

Trauma and Psychology

The DSM IV-TR defines trauma as having the following two components: The event involves "actual or perceived threatened serious injury or death to oneself or others;" and "the individual's response must include intense fear, helplessness, or horror" (APA, 2000, p.218).

Neuroimaging studies of the traumatized brain have discovered lasting changes that occur post-trauma. For instance, traumatized people's executive function becomes less active (van der Kolk, McFarlane & Weisaeth, 1996) when stressed. When traumatic stimuli are present, the traumatized person's executive function is less active, making them prone to "automatic behavioral flight, fight, or freeze responses that are our evolutionary heritage of dealing with threat, and our individual implicit memories of how our own bodies attempted to cope with the threat of being overwhelmed" (Ogden & Pain, 2006, p. xxi). Trauma, thus, leaves an imprint on the body, and once triggered, the individual can relive the physical sensations of terror and helplessness that once accompanied the original traumatic event (Ogden & Pain, 2006). The extracellular environment has been implicated in trauma memory's resistance to extinction. While extinction has been found to consist of new learning, it does not erase the trauma imprint. It can "spontaneously recover, or be renewed, when the conditioned stimulus is presented in

contexts different from that in which the extinction protocol was administered" (Pizzorusso, 2009, p. 1214). The surviving therapist who works with trauma is, therefore, continually exposed to traumatic stimuli in the complex context of therapy with another human being.

Countertransference

Freud (1910/1957) defined countertransference as that "which arises in [the therapist] as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it" (p. 144-145). Freud and others noted that the body had its own story to tell (Ross, 2000). Symptoms and signs, Freud 1893-1895/1985) said, "join the conversation" through the body (p. 152). Samuels (1985) recognizes a modern analytic consensus that "...some countertransference reactions in the analyst stem from, and may be regarded as communications from the patient and that the analyst's inner world, as it appears to him, is the *via regia* into the inner world of the patient" (p. 51). In a footnote Freud (1912/1961) explained that:

> [the analyst] must turn his own unconscious like a receptive organ toward the transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone. Just as the receiver converts back into sound waves the electric oscillations in the telephone line which were set up by sound waves, so the doctor's unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct that unconscious, which has determined the patient's free associations. (p. 115)

Somatic countertransference refers to the therapist's bodily experience when in a therapy session (Ross, 2000). Dalenberg (2000) states that particular attention to the therapist's reactions

to their trauma clients, and their own countertransference, is an essential ingredient to creating a safe alliance with trauma patients.

Current trauma literature is unanimous in its prescription of a safe therapeutic alliance as essential for trauma work to commence (Pearlman & Saakvitne, 1995). It is "not until trust in the therapist is established does the client have an ally with whom to confront the traumas" (Rothschild, 2000, p. 84). Without this trust, the client is once again left alone to process the traumatic memories. When this occurs, "not only is the trauma not resolved, but it also can be made considerably worse" (p. 84).

The experience of a safe therapeutic alliance is particularly important for patients who have experienced a human-caused trauma. Schore (1996) writes of the therapeutic relationship's capacity to be stored in implicit memory, creating synaptic connections in the brain that can provide a new experience of positive attachment. This internalization creates a somatic representation that can replace anticipated fear and anxiety responses in new relationships, allowing for a renewed interest in healthy connection with others.

For some patients, trust will take considerable time to earn. The therapy will focus largely on developing trust and processing of traumatic material will not be addressed directly. The traumatic material instead manifests within the therapeutic relationship. In these instances, trauma is worked by utilizing the client's transference and the therapist's countertransferential experiences (Rothschild, 2000). For instance,

> the therapist remains alert to inner experiences that arise in the context of therapy that feel foreign to him. These signal the therapist as to what cannot be spoken or dealt with by the patient. In digesting this material, the therapist provides a model for the patient about how to deal with the originally unacceptable material. For instance, the therapist

> who disentangles himself from a victim position in relation to a persecuting patient without adverse affect on the relationship provides a new model of dealing with victimhood. (Roussillon, 2010, p. 1412)

Patients watch as their therapists receive, tolerate, make sense of, and integrate emotional experiences. Just as parents will take a bite of baby food to show to the infant that is palatable, therapists can show patients that trauma-associated affects can be taken in and broken down.

Rationale

While surviving therapists are encouraged to examine the personal impact of their trauma and understand how this may affect their work with traumatized patients (Walker, 1984), there is little in the literature as to how to do this. Cunningham (1996) notes that further qualitative study in the area could help in providing a detailed depiction of the surviving therapist working with trauma patients. Although the literature on trauma continues to expand, it has been relatively silent in the domain of the therapist's own trauma as a factor in treatment. Furthermore, victims of trauma often have difficulty communicating the intense emotional and inner experiences they face. van der Kolk (1998) explains that trauma memories are unique in that they are encoded in high levels of stress hormones. The verbal encoding system becomes inactive, and the memory is encoded as a sensory and visual memory characteristic of early childhood. People with trauma may have sensory experiences related to trauma for which they can find no conscious meaning (van der Kolk, McFarlane, & Weisaeth, 1996). Others may have no memory of the trauma, a common reaction to an overwhelming event (van der Kolk et al., 1996), and have no frame of reference to understand trauma-related somatic experiences. Surviving therapists will need to contain both their own and their patient's trauma-associated reactions and may have difficulty

using words to describe their subsymbolic experience in supervision. Regressions to earlier stages in development present serious challenges to the process of containment.

Affect development. The ability to verbalize affective states is crucial to the capacity to identify, experience, tolerate, and work with emotion. Attuned caregivers aid in the naming and symbolization of affect leading to the affective state becoming integrated. Caregivers soothe infants before affect becomes too overwhelming. Frustration is titrated, and allows for the infant to build a tolerance.

> If: *All goes well* the infant can come to gain from the experience of frustration, since incomplete adaption to need makes objects real, that is to say hated as well as loved. The consequence of this is if *all goes well* the infant to begin to develop a capacity to experience a relationship to external reality, or even to form a conception of reality. (Winnicott, 1971, p. 14)

This process lends to the emergence of self and objects (Krystal, 1997). Stern (1951) notes that when the baby is not soothed by the mother after a short time, a type of trauma occurs where the baby is in a state of over-excitation and this is the onset of the infantile traumatic state. These early types of trauma lay down the traumatic foundation (or lack of foundation) and affect how later traumatic events are experienced and structured. In post-traumatic states "we may find a regression in affect form with resomatization and decreased ability to use affects as signals to one's self" (Krystal, 1997, p. 129). This is the return to the experience of being unable to process affect. With no blanket of symbolism or verbal access, the body is left with no symbolic breast or internal soother. Symbolism allows for naming of affect (i.e. sad, angry) and this symbolism aids in decision making to contain the affect or change the external stimuli. An actively traumatized therapist will be unable to use affect as a signal and will be unable to use their own reactions in

understanding the patient. Healed therapists will struggle with unhealed wounds that impact the use of symbol to process and contain trauma-associated affect.

Somatic experiencing is but one channel in a larger non-verbal system linked with emotion, thought, and language in normal development. As language develops, non-verbal schemata can be linked to language. Somatic symptoms represent dissociation as they have become alienated from the larger system (Bucci, 1997).

Trauma and affect. Resomatization (somatic sensation disconnected from other verbal/emotional channels) could represent an arrest due to infantile trauma, regression following an adult trauma, or due to intense affect in the adult. In these states, one is again unable to utilize affect effectively as a signal (Krystal, 1997). The therapist's task is to supply "belatedly, a function that the patient's parental and familial background has failed to perform. To be able to function in such capacity, however, one must appreciate the nature of the subjective experience of patients whose affect tolerance is impaired" (Krystal, 1988, p. 29). Surviving therapists may have an appreciation of affect tolerance disturbance; however, they may have difficulty containing and aiding in symbolization when their own affect is trauma-related.

However, sensory information that is not linked to a symbolic system may relate to Odgen's (1989) "autistic-contiguous" position (p. 30). This position is a primitive mode of experiencing in which sensation is used to form presymbolic connections having to do with the edges of objects and sensory data. This is the beginning of self in that the infant begins to have some sense that there is an external world. Touch allows the establishment of boundedness. The edges of objects are the barrier between self and not-self and tactile stimulation confirms the boundary. The mother and child dyad are involved in sensory activities (i.e., cooing, nursing, cuddling) that help to make bearable the growing awareness of separateness (present in the

exploration of the edge of self and other). The skin is the "principal media for the creation of psychological meaning and the rudiments of the experience of self" (Ogden, 1989, p. 52). If the mother is unable to provide healing for these separations by providing sensory experience, states of psychological deadness can occur in which the meaning making process is paralyzed. Anxiety in this position involves the fear of one's dissolution, manifested in fears of one's bodily contents leaking or fear of falling (Ogden, 1989). Traumatic events violate the body's basic level of integrity through invasion, injury, and force. The control over bodily functions and fluids can be lost during a traumatic event and may be recounted as one of the most humiliating aspects of the event (Herman, 1992). Thus, trauma-related somatic sensations may invoke basic anxiety related to the autistic-contiguous position, and regression to this position may correspond with a paralysis in the meaning making process in sensory experiencing.

The therapist's in-session somatic sensation may be unique from other internal stimuli and not experienced as primarily physical, as "everyone, including people who may be considered to have completed a successful analysis, is convinced that they cannot control the parts of their bodies that are innervated by the 'automatic' nervous system" (Krystal, 1997, p. 141). Therapists may have personal trauma triggered and feel they are helpless to soothe themselves (a state that could result in the traumatic response). For some people, "taking over functions reserved for [the] mother is a *Promethean Transgression punishable by a fate worse than death*, which is the return of the infantile trauma" (p. 141). Thus, there can be resistance to self-care and self-regulatory functions (functions felt to be reserved for the mother) that usher in the surrender of the traumatic process (Krystal, 1997).

Supervision, accommodation, and exploration. Batten and Santanello (2009) write of the importance of the supervisor's attention to the trainee's emotional reactions to the client, as

these reactions are often indicative of the client's impact on others. Sarnat (2010) writes of the core competencies of the psychodynamic psychotherapist. Within the assessment competency, the psychodynamic psychotherapist considers the whole person by accessing the channels of spoken language or symptomatology but also tapping into unconscious communication in the form of somatic experiences. The psychodynamic competency of self-reflection requires a "highly developed capacity to bear, observe, think about, and make psychotherapeutic use of one's own emotional, bodily, and fantasy experiences when in interaction with a client" (Sarnat, 2010, p. 3). The intrapsychic conflicts people have and the ways they manage the anxiety stemming from these conflicts are highly related to early somatic and affective experience. These experiences are most "evident in the psychoanalytic encounter and [are] arguably the heart of psychoanalytic clinical work" (Fonagy & Target, 2007, p. 425).

Batten and Santanello (2009) write that a "supervisory focus on trainee's emotional awareness is essential in that it may help to avoid in-session avoidance on the part of the trainee" (p. 148). The authors explain that avoidance in supervision of the trainee's reactions may also increase shame and negatively impact the development of the trainee and the progress of the clinical work.

Wilson and Lindy (1994) define "trauma specific transference" (TST) reactions as occurring when the client interacts with the therapist on the basis of unintegrated traumatic material (p. 9). This includes emotional states, roles, and behaviors. Davies and Frawley (1994) describe countertransference with trauma as often being formless. They note that therapists have found themselves "inexplicably nauseous, terrified, bigger, or smaller, have had tingly skin, numbness in an extremity, headaches, dizziness, vaginal pain, or contractions, or have experienced states of sexual arousal, all of which were disorienting and alien to a normal

function ego" (p. 151). Because the client may unwittingly enlist the therapist into the role of perpetrator, victim, or bystander, the therapist's countertransference may reflect any of these roles at different times (Wilson & Lindy, 1994).

In Racker's (1969) definition of "concordant identification," he explains that in such moments therapist and patient are experiencing at the same time an element of the patient's self-experience. Money-Kyrle (1956) wrote of the ways in which the analyst's experience of countertransference is often very similar to some aspect of the patient's inner experience:

> If the analyst is in fact disturbed [and here it is implied that the analyst is inevitably disturbed in the sense of affected], it is also likely that the patient has unconsciously contributed to the result, and in turn is disturbed by this. So we have three factors to consider: first, the analyst's emotional disturbance, for he (she) may have to deal with this silently in himself before he can disengage himself sufficiently to understand the other two; then the patient's part in bringing it about; and finally, its effect on him. Of course, all three factors may be sorted out in a matter of seconds, and then indeed the countertransference is functioning as a delicate receiving apparatus. (p. 361)

Somatic sensation can be used to understand something of the patient's experience. However, once a therapist gains an observational stance, it may be useful for them to make sense of the "disturbance" and its relation to the patient. If the patient's material touches upon the therapist's repressed traumatic schema, the therapist may have an unconscious investment in keeping the "big picture" of their own trauma at bay by disconnecting verbal understanding from somatic sensation, perhaps through repression or regression. When processing of countertransferential reactions takes place in seconds, there is a reliance on subsymbolic data and an implicit awareness of the patient. As surviving therapists have experienced events they may

unconsciously choose to keep out of awareness, they may rely on adaptations in the face of regression, repression, and dissociation which can distort their ability to act therapeutically in a moment that requires swift clinical reflex.

Finally, the gap in the literature regarding the experience of surviving therapists may inhibit therapists who are struggling with unique countertransferential reactions. The literature's silence, however benignly born, may act as a shaming force to keep surviving therapists quiet about their own histories. While research has suggested that there are common countertransference reactions that arise when working with surviving patients, the phenomenon of the surviving therapist's experience of working with surviving patients remains to be documented (van der Kolk et al., 1996).

van der Kolk et al. (1986) write that, with little knowledge of the surviving therapist's unique challenges and the accommodations they make to these challenges, surviving therapists may miss out on valuable information that could improve their work with traumatized patients. Marks-Tarlow (2011) writes that change happens at the "edge of chaos" in which "hidden order is invariably tucked beneath what may be random on the surface" (p. 120). He found change possible when working on the "edge of affect-tolerance" in himself and his patient (p.120). Entering into the fertile edge of chaos requires enough containment to experience difficult affect states. Helplessness in the surviving therapist, the hallmark of trauma, must be contained for the therapist and patient to stay on the edge of chaos. Just as chaos contains elements of "old and new mixed together" surviving therapists will have their old traumas reawakened in working with their trauma patients. For both parties interacting in fertile chaos, the opportunity for healing and growth exists. In terms of the therapist's survival it is "imperative that, in the clinical equation, the psychic boundaries and processes of at least one party, mainly the analyst, should

always be defined in terms of their functions and aims" (Kahn, 1974, p. 206). In surviving and being used by the patient, the therapist must tolerate self-states of helplessness, rage, and terror *without* transference interpretation distorting "the true dynamics of the analytic situation in terms of the bias of our theories, and regardless of the need of the patient and his psychic realities" (p. 206). Surviving therapists may have learned ways that allow them to venture to the edge of chaos (without complete loss of self) and to tolerate experiencing themselves (and their spirits) and their patients in these territories, surviving (not prematurely ejecting through interpretation or retaliation) as the "living and responsive part of the total environment that the patient has put himself in the care of" (p. 206).

Theoretical understanding of how surviving therapists survive, or do not survive, or struggle to survive in these territories could allow for supervision, training, and theory that could enhance the likelihood that therapists can journey along the edge of chaos with access to all their spirits as guides.

Areas of Inquiry

1. What is unique to the experience of the surviving therapist working with trauma?
2. Do surviving therapists re-experience elements of their own trauma when working with trauma patients?
3. Have participants experienced a session when both patient and therapist were experiencing elements of their respective traumas? Can they describe this experience? How did they realize it was occurring?
4. How do surviving therapists recognize and utilize somatic countertransference with their patients?
5. Do surviving therapists experience their work with trauma patients as being different from patients who have not experienced trauma?
6. How do surviving therapists utilize supervision when they are triggered, especially when symbolization is difficult?

7. Do surviving therapists see themselves as more able to pick up unintegrated traumatic data from their patients? How do they use their inner experiences to understand the client?

8. Can therapists speak to experiences in which somatic countertransference helped to understand something of the patient's subjective world or traumatic experience?

Chapter 2

Literature Review

This portion of the dissertation illuminates what is known about the types of trauma, response to trauma, and the surviving therapist's unique experience. As others have noted, what is lacking in the literature is as important as what exists. Pearlman and Saakvitne (1995) refer to this as the "conspiracy of silence," encouraging surviving therapists to keep quiet about their experiences. As this study proposed to fill in some of these gaps and silences, it must first detail what has already been spoken.

Types of trauma. As different types of trauma have different effects, it is necessary to explicate the more common categories of trauma and explain how they may affect a person. However, as early traumas (non-verbal, developmental) shape and impact the way later traumas are structured and experienced, categorization is often a difficult and artificial representation of a person's actual history as they may be unable to recall earlier events due to repression or age.

Generally speaking, traumatic events caused intentionally by another (i.e., interpersonal violence, rape, combat, terrorist attacks) are more likely to cause impairment than trauma unintentionally caused by another person (e.g., car accidents, industrial accidents) or natural disaster (Everly & Lating, 2004; Hien, Litt, Cohen, Miele, & Campbell, 2009). Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) found rates of PTSD from non-interpersonal trauma (natural disaster, witnessing a traumatic event, or accident) for men are 4–6% and 5–9% in women. In interpersonal trauma, PTSD rates associated with rape, molestation, physical abuse, and physical attack ranged from 2–65% in men and 21–49% in women (p. 1925). Trauma outcome is worsened when the perpetrator is responsible for the care of the victim (van der Kolk & Fisler, 1994). It is reasonable to assume that somatic countertransference may occur more frequently

within an interpersonal context when the source of trauma was interpersonal. Thus, this study focuses on surviving therapists whose trauma was due to intentional human action.

Childhood trauma. Childhood trauma occurs in a time when the person and the nervous system are still in the process of forming. Childhood trauma has the potential to impact the long-term psychological functioning of an individual (Everly & Lating, 2004). Every year, approximately three million children are reportedly victims of abuse or neglect, and one third of these cases are substantiated (U. S. Department of Health and Human Services [USDHHS], 2003). Community based incidence studies have found that reported cases of child abuse and neglect account for only about 40% of actual cases (USDHHS, 1988).

Childhood trauma has been noted to cause chronic PTSD symptoms well into adulthood, as well as difficulties in personality, interpersonal problems, affect dysregulation, and dissociative phenomena. When looked at as a group, these difficulties are referred to in the literature as "complex PTSD" (Everly & Lating, 2004, p. 26). People who are exposed to early trauma have been shown to have an increased risk of revictimization (Widom & Maxfiel, 1996). Furthermore, experiencing trauma in childhood has been shown to exacerbate reactions to later trauma that may occur (Everly & Lating, 2004).

Finally, children who have suffered abuse have been found to have neurological damage, even when they have not incurred head injury (van der Kolk et al., 1996). Abnormalities have been observed in their catecholamine, serotonin, and endogenous opiate systems (van der Kolk, et al., 1996). Fullilove (2009) found that childhood sexual abuse affected multiple systems and subsystems of the body, resulting in numerous comorbidly occurring psychiatric and physical conditions. The study determined that childhood sexual abuse is the "equivalent to adding eight years of life" (p. 1) on illness strain, but the results were more extreme in the area of body pain

and daily life activities, where the illness burden was equivalent to 20 years of living.

Rape and sexual assault. The National Violence Against Women Survey (Bachman & Satlzman, 1995) defines rape as "an event or threat of force to penetrate the victim's vagina or anus by penis, tongue, fingers, or object, or the victim's mouth by the penis" (p. 4). It is an act of humiliation and violence which threatens not only the victim's existence, but also sense of self and identity (Hilberman, 1976; Sanders, 1980).

The definition of sexual assault most often is defined as any forced sexual act that does not meet the definition of rape. Rape is the most common event in which PTSD is diagnosed, although some advocate that Rape Trauma Syndrome (RTS) more accurately describes the reported experience of rape victims (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993). Symptoms of RTS include PTSD but expand to incorporate self-destructive behavior, impulsivity, dissociative symptomatology, shame, and loss of previously held beliefs (Jackson & Tobin, 1996). Victims of rape are also more likely to use alcohol and drugs in order to cope with traumatic memories, more likely to suffer from anorexia and bulimia, and are more vulnerable to subsequent victimization than those who have not been raped (Lipman, 2002). Symptoms of PTSD and RTS can last indefinitely—as one study found that victims of sexual assault continued to have elevated scores on the Trauma Symptom Inventory 14 years after the event occurred (Elliott, Mok, & Briere, 2004).

Combat trauma. The traumas of war are variable, as each war has different characteristics (i.e., culture, type of combat, and branch of service; Everly & Lating, 2004). Grinker and Spiegal (1945) observed that the strength of the fighting unit's cohesion and morale was the strongest preventative measure against psychological breakdown. The post-trauma environment can also have a significant effect on veterans. Homecoming experiences vary

depending on the political climate surrounding the war and affect post-war coping (Schlenger & Fairbank, 1996).

The effects of war are also quite variable, including anxiety, dissociation, aggression, substance abuse, and suicidality (Berthold, 2000). PTSD is the most common of all psychological sequelae, with occurrence rates for veterans being 8.5% for females and 15.2% for males (Everly & Lating, 2004, p. 27). Everly and Lating note that 30.6% of male Vietnam veterans and 26.9% of female Vietnam veterans have a lifetime occurrence of PTSD and that incidence of lifetime PTSD is higher in those who were exposed to greater amounts of combat.

Somatic Countertransference

Proner (2005) imagines that "every analytic psychotherapy session is replete with material of a somatic nature probably in every session" (p. 311). In one research study, Samuels (1985) found that 46% of the cases of countertransference are somatic in nature (p. 9). While this may be true, the literature still lacks much exploration of the phenomenon. Miller (2000) reasons that the paucity of material on somatic experiences may be due to an overall fear of attending to the therapist's and patient's body, perhaps due to cultural factors. Western cultures hold the mind supreme, and the "body beastly" (p. 441). Miller notes that children are socialized to be still and quiet, to use the mind to control emotions. Therapists identify with a quiet, scholarly way of being, and Miller explains that this may inhibit them from being attuned to their own bodies. He mentions that it is only through personal communications that he is ever aware of how practitioners are thinking and making use of the body in their work. He writes about a case in which he "became aware of my hands going very cold and stiff" (p. 446) and his client then explained his own feelings of coldness and stiffness. This related to the client's surfaced memory of being strangled. He describes the use of sensation as a valuable clinical tool that enables the

therapist to understand something of the client's unconscious messages to the therapist and the self.

Alexander Lowen (1971), a student of William Reich, believes that all traumas are stored in the body and it is possible through body movements for the trauma to become conscious and be worked with analytically. Ogden and Pain's (2006) model of sensorimotor therapy builds on existing models of psychotherapy but advocates for a central focus on the body in the healing and integration of trauma. They see traditional psychotherapy as adhering to a "top-down" approach which utilizes verbal recollection of painful past events, emotions, and cognitions to effect change. Ogden and Pain's (2006) model proposes the use of:

> "bottom-up" interventions that address the repetitive, unbidden *physical* sensations movement inhibitions, and somatosensory intrusions characteristic of trauma.... By including body sensation and movement as a primary avenue in processing trauma, sensorimotor psychotherapy teaches the therapist to use body-centered interventions to reduce these symptoms and promote change in the cognitions, emotions, belief systems, and capacity for relatedness in the client. (p. xxix)

Miller (2000) explains that the therapist who considers and works with the body provides a "model of the embodied person, a self-object in the therapist who is active and alive, who sees the body as a source of pleasure and not only suffering" (p. 440). Miller explains that as practitioners, not attending to the body is evidence of blocking and defending. Haven and Pearlman (2004) write that "when the body is left out of psychotherapies with trauma survivors, a re-enactment is taking place. The body again is a source of shame, the repository for a terrible secret" (p. 222). Miller notes that "trusting body sensations and body observations will turn the dreaded, the often-denied fear of the body into a helpful contribution to working with our

patients" (p. 448).

Field (1998) views unconscious bodily reactions as "nearer to the heart of the matter," and not simply peripheral phenomena (p. 512). Furthermore, Field explains that the therapist's body is an "organ of perception," that indeed feels the sensation in a very real way, acting as a place where participants' worlds intermingle (p. 210). Samuels (1985) defines embodied countertransference as "intended to suggest a physical, actual, material, sensual expression in the analyst something in the patient's inner world, a drawing together of the solidification of this" (p. 52). One can see this in terms of Winnicott's (1974) transitional space, in which the patient's internal world is communicating directly to the therapist's.

In thinking about why some clinicians are more likely to experience somatic countertransference than others, Jacobs (1973) wonders:

> ...how can we explain the fact that this route is more available to some analysts while others can make relatively little use of it? …It seems possible that the experience of being confronted consistently with material relating to intensely conflictual bodily experiences may serve to increase the analyst's own bodily awareness and facilitate this pathway as a route to comprehension. (p. 91)

In terms of which patients are likely to induce embodied countertransference, certain characteristics have been identified, including pre-verbal trauma, narcissistic and borderline phenomena, instinctual difficulties, and traumatic events (Stone, 2006, p. 118). It may be that if trauma stimuli overwhelm the language part of the brain, other ways of communicating are relied upon. Dissociation and displacement may disconnect the emotion from the internal representation, leaving information to be conveyed through subsymbolic channels (Bucci, 1997).

The skin, for example, may act as another screen that relational histories and emotions

can be projected onto (Scharff & Scharff, 1994). Bick (1968) notes that "in its most primitive form the parts of the personality are felt to have no binding force amongst themselves and must therefore be held together in a way that is experienced by them passively, by the skin functioning as a boundary" (p. 484). Ashley Montagu (1971) writes that skin is the infant's foundation for human attachment and socialization, and that the "communication the infant receives through the warmth of the mother's skin constitute the first socializing experiences of life" (p. 77). In traumatic states, verbal systems of communication are overwhelmed, and it may be that earlier mechanisms of attachment and communication become the primary mode of relating (van der Kolk et al., 1996). The surviving therapist is perhaps uniquely able to pick up these communications and use them to understand something of what the client is expressing (Field, 1988).

Bucci (2001) describes unconscious communication as transmission of a subsymbolic experience (and, thus, unverbalized experience) from the patient to the analyst:

> The affective communication of one individual—in sensory and motoric as well as verbal form—is received and known through the sensory systems of the other, as well as through feedback from the motoric systems that are activated in response. Thus the subsymbolic expressions of the patient, components of his dissociated or displaced emotion schemas, activate subsymbolic experiences in the analyst that are components of the analyst's own schemas. The analyst "knows" his own emotion by the activation of its affective core, by the sensations and visceral experience he feels, by the actions he feels drawn to carry out—as Bernini *knows* the characteristics of a piece of marble in his muscles and Balanchine *knows* the movements of a dance. (p. 49)

Ogden (1989) wrote specifically that the analyst's "somatic delusion, in conjunction with

the analysand's sensory experiences and body-related fantasies, serves as a principal medium through which the analyst experienced and came to understand the meaning of the leading anxieties that were being (intersubjectively) generated" (p. 95). It is a type of shared identification with the material that leads to the therapist's knowledge of the patient's internal unsymbolized experience (Bucci, 2001). Thus, if a therapist suddenly feels as if they may vomit in a session with a patient they may deduce through the somatic sensation, the content of the session, and their understanding of the patient, that the patient's anxiety is related to the autistic-contiguous mode of experiencing.

Professionally, therapists are not as used to working with preverbal memories that are experienced as primarily somatic (Krystal, 1988). Krystal encourages further exploration into these states, adding that "too many analysts and therapists of all kinds are alexithymic and/or anhedonic" (p.145). He alludes to the ways in which therapists continue to wait for somatic experiences to be able to be translated into words and symbols by the patient, but that this never happens. This then becomes the task of the therapist. It is not clear how this occurs when a therapist may be experiencing the phenomena in somatic, pre-verbal form. Supervision often relies on the ability to put feeling states and countertransferential reactions into verbal form and may be hindered by the inability to use the symbolic/verbal system to represent the affect state occurring in the therapist. Supervisors may benefit from maintaining a curiosity in supervisees' somatic sensations, struggling to understand what may be being communicated through subsymbolic channels.

Vicarious Traumatization

Vicarious traumatization (VT) is considered an expectable result of working empathically with trauma survivors (Pearlman & Saakvitne, 1995). VT is defined as separate from

countertransference. Notably different from "burnout," VT involves a permanent shift in worldview and self-experience. Brown (2008) sees this shift as a place in which the therapist can connect empathically with the client's experience of trauma:

> an inner place from which a psychotherapist can join empathically with trauma suvivors in ever more profound ways. If I can become aware of and know how simply witnessing stories of trauma affects me I have an experiential base that allows me to validate the transformational power of direct trauma exposure in an emotionally truthful manner; when my patients hear and feel my responses to their stories, they can hear and feel a resonance that has its roots in VT. (p. 252)

Brown sees VT as a source of strength in therapists, enabling them to be more connected and empathic with patients' experience of trauma. She notes that survivors of trauma often develop a heightened attunement to the subtle emotional experience of others, and that VT can also foster this in the therapist. Laura van Dernoot Lipsky and Connie Burk (2007) use the term "trauma stewardship" to refer to the "entire conversation about how we come to do this work, how we are impacted by our work, and how we subsequently make sense of and learn from our experiences" (p. 32). They note that the more personal one's connection with their work, the more advantages they may bring to it. Risks of countertransference impeding therapy may also heighten when identification with the client exists. They write about a "rawness" (p. 42) that occurs with the trauma patient/therapist match, a rawness that can cause therapists to literally feel their patient's pain.

The Surviving Therapist and Countertransference

Although Waites (1993) does not specifically mention the surviving therapist, she does

reflect that the traumatized patient's hypervigilence may be an asset in some "personal and vocational situations" (p. 31). She also names an increase in the capacity for creative and artistic endeavors, but the mechanics of hypervigilence and creativity are not explored. While it has been suggested that the therapist's memories of pain can create in them a capacity to tolerate and accept the pain of others (Pearlman & Saakvitne, 1995), the vulnerabilities of empathic repression and over-investment of the surviving therapist are more frequently attended to in the literature. For instance, Dalenberg (2000)) cites "empathic repression" as occurring when a therapist becomes disconnected in therapy without acknowledging the disconnection. In one study, two of the seven surviving therapists studied explained that they had a desire to avoid potential triggers of their own trauma (Wilson & Lindy, 1994). Over-investment is described as the therapist becoming empathically enmeshed with the client. (p. 74).

Briere and Scott (2006) write that surviving therapists' countertransferential responses could either cause the client to have a negative experience, or impede the therapeutic process (p. 83). Furthermore, the therapist's unresolved trauma may unconsciously cause their client to deny or avoid their own traumatic material. Distancing in the therapist may be an attempt to keep personal trauma from being triggered and resentment of the client may occur when attempts to avoid traumatic material fail. This effect seems compounded when one considers what many have found to be true, that the traumatized client is perhaps particularly aware of such behavior as tone of voice and avoidance of participants (Pearlman & Saakvitne, 1999). Briere and Scott (2006) suggest that when the therapist's trauma impedes the therapeutic process, he/she should consider either psychotherapy or consultation with a therapist who is familiar not only with trauma, but also with the therapist. Pearlman and Saakvitne (1995) also note the increased potential for difficult identifications and boundary crossings when both therapist and client share

a trauma history.

Dissociation. Dissociation is a key component of trauma. Unlike repression, dissociation causes a split ego that creates self-states that operate independently. In childhood trauma, the child must preserve the delusion of a good parent, even if this parent is the person inflicting abuse. Otherwise, the intense feelings of rage and terror would threaten to annihilate the concept of self. Splitting enables the child to compartmentalize and preserve the promise of a good parent who will turn hate into love. This type of vertical splitting protects images of self and parent from ever coming together, and the delusional good parent is maintained (Kohut, 1971). Emotions and thinking become distorted and history and present are disjointed so that the full picture is not brought into consciousness. These ego-states are not accessible to the personality. Instead, they come into awareness through repetitive images, nightmares, enactments, and somatic experiences (Janet, 1889; van der Kolk & van der Hart, 1989).

Projective identification. Pearlman and Saakvitne (1995) acknowledge the nature of working with trauma in that much of the communication is through projective processes. While they note that most therapists working with these projections will likely experience some dissociative phenomenon themselves, therapists with a history are more susceptible to experiencing dissociation in-session.

Projective identification is a psychic maneuver that has both defensive and communicative properties (Tansey & Burke, 1958). It is a process between two people in which the projector unconsciously elicits his internal experience in another. A projection that becomes a projective identification requires on the part of the receiver an introjective identification. Thus, the patient may project a state in the therapist that relates to the patient's self experience or from any of their object representations (Kernberg, 1979). For instance, a patient with sadomasochistic

dynamics may communicate his sense of victimhood through invoking through the relationship an impulse in the therapist a desire to attack. Or, the patient may take on the sadistic self-representation, and elicit in the therapist a feeling of victimization (Tansey & Burke, 1958).

Tansey and Burke (1958) delineate three stages involved in the process of using a projective identification; reception, internal processing, and communication.

Reception incorporates Bion's (1969) concept of "containment" to illustrate the therapist's process of allowing the communication of the patient and tolerating the corresponding self-state arousal that occurs internally. These feelings are tolerated without prematurely pushing them away. The therapist thus experiences a signal affect (Schafer, 1959). This signal can either lead to a dismissal of the experience or awareness in the therapist that some sort of identification has occurred (Tansey & Burke, 1958). Developmental trauma can cause an impairment of the ability to use affect as a signal to one's self (Krystal, 1997). Affect is experienced but often in the form of increasing anxiety. With an impaired ability to recognize affect as a signal to act upon one's internal or external environment the result is often increasing affect with no adaptive function (Freud, 1933). Thus, therapists who have had developmental trauma may have difficulty recognizing when a projective identification has occurred and this will inhibit them in seeing it as relating to their patients' internal worlds.

The *internal processing phase* involves the therapist's handling of the communication. Containment-separateness involves the therapist gaining a sense of perspective, or distance, from the identification. Observational capacity depends on the therapist's suspension of super-ego criticism and maintenance of self-esteem through an understanding that the identification is temporary. The therapist attempts to develop an internal model of the therapist-patient interaction and "acquire the affective and cognitive knowledge of the participant's experience of

both participants so that the determination as to the degree of concordance or complementary between these experiences can be made" (Tansey & Burke, 1958, p. 57). This phase leads to a deeper empathic understanding of the patient (Tansey & Burke, 1958).

The *communication phase* involves giving back to the patient something of what has been discovered. The first sub-phase is silent communication. Here, the therapist communicates something of his understanding through tone of voice, expression, etc. and he "is able to contain the feelings he has about himself and the patient" (Tansey & Burke, 1958, p. 61). The therapist may have a deep understanding of the projective identification, but may stay in this subphase for clinical reasons such as the patient's capacity to receive the interpretation (Bollas, 1992; Tansey & Burke, 1958).

The later communication subphases include communicating something of one person's experience of the interaction. Here, the therapist is still processing the identification but speaks to some element of the communication he has received. The final subphase includes both parties in the interaction, and includes something of both self-states of therapist and patient (Tansey & Burke, 1958). For instance, after listening to a patient's description of hopelessness in a first session, a therapist may feel that he is inadequate to help. The therapist may recognize his sense of inadequacy as a signal of the patient's doubt that the therapy can be useful in helping him. The therapist could comment on both self-states by saying "I believe I have some sense of your feeling that there is little if any hope for the future. Perhaps you doubt whether I will really be able to help you?" (Tansey & Burke, 1989, p. 62).

Therapists with trauma histories may habitually take a masochistic position with trauma patients, inciting sadistic attacks from their patients through their self-destruction or "abusive acting out" (Davies & Frawley, 1994, p. 166). Conflicted about their own aggression, an

unconscious agreement between patient and therapist is made: the patient will carry out the therapist's disavowed aggression for both parties. Therapists may also be uncomfortable with their identification with their own abusers and, thus, be unable to allow themselves to be used by the patient as a bad object (Davies & Frawley, 1994). Masochism may be connected to the moral defense, a taking in the bad aspects of the object in order to have a sense of control (Fairbairn, 1952). Seeing oneself as deserving of the patient's sadism also suggests an interest in one's internal badness to preserve the original tie to a depriving object.

Enactment. Plakun (1999) recognizes resistance to negative transference as common in enactments involving therapist misconduct. He notes that these types of enactments occur when the patient projects disavowed aspects of themselves onto the therapist and the therapist projects back into the patient their own conflicted countertransferential material. In enactment, the "therapist may be thought of as joining in the process that moves the therapist away from neutral acceptance of the transference" (p. 288). Stern (1997) sees enactments as places of mutual dissociation of patient and therapist. Enactments are inevitable and they can be used to deepen the therapist's understanding of the patient and further the work. They can also be unexamined places in which the therapist does not survive, leaves their post or role as therapist, and ends up damaging the patient. Surviving therapists can drift towards non-survival by moving toward action and not tolerating the transference. Pearlman and Saakvitne (1995) write that in incidences of trauma patient/therapist match, therapist and client may be reliving aspects of their respective traumas at the same time. Accepting the patient's transference can mean tolerating one's own self states associated with trauma, including the perpetrator, victim, bystander, witness, rescuer, seducer, and seduced (Davies & Frawley, 1994).

Pearlman and Saakvitne (1995) and others note that traumatized patients, more so than

other populations, provoke deep reactions and tend to bring up unresolved issues in the clinician. Peebles-Klieber (1989) explains that therapists working with trauma have a "heightened vulnerability to split off projection from their patients. These split off aspects of the patient are unmetabolized and unintegrated into the person's self-experience, so they exist as unstable particles in the patients internal world and are ripe for projection onto another" (p. 519).

Frawley and Davies (1994) also describe ways in which having a trauma history may enhance the therapist's effectiveness. Therapists with trauma, they explain, can empathize with the "terror, rage, and loss" at "levels that nonabused clinicians may never reach" (p. 166). Perhaps the reason is that therapists with trauma in their backgrounds are more likely to identify with the disowned projected aspects of traumatized patients.

Surviving therapists who work with trauma will find in themselves foreign self-states that may cue them to understanding what their patient is communicating to them. They may experience intense feelings of rage and loss associated with spirits from their own pasts, and they may have difficulty recognizing these spirits as stemming from their own histories. Even the sense of having identified with a self-state most often kept out of awareness may increase anxieties related to basic concerns about bodily integrity related to trauma. However complicated, therapists can use their reactions to begin to integrate, reconstruct, and rework the patients' trauma memories so that they can be mourned as occurring in the past rather than relived in the present.

Chapter 3

Methodology

While some quantitative studies have conducted research on the surviving therapist and patient match (Mathews & Gerrity, 2002), it is the surviving therapist's perspective that is often missing from the literature. Qualitative research recognizes the socially-constructed reality of participants and honors the process of meaning making through dialogue (Creswell, 2007). As conversation is one method of understanding the experience of another, conversation was used to uncover subjects' complex experiences.

Grounded theory. A grounded theory approach was used in this phenomenological study to systematically categorize, analyze, and conceptualize interview data and construct theory (Charmaz, 2003). Grounded theory goes beyond description to create "an abstract analytical schema of a process" (Creswell, 2007, p. 63). As the purpose of this study entails the *process* of surviving therapists working with their own reactions, the method's ability to uncover process and theory was indicated. While theory surfaces, it is incomplete (Charmaz, 2003).

Grounded theory's tendency toward trying to understand the experience of its participants, while retaining the ability to ask interpretive questions around subtext, allowed for the flexibility and complexity that was essential to this study. "Rich data" that provides "views of human experience that etiquette, social conventions, and or inaccessibility hide or minimize" allowed for depth in exploring subsymbolic processes (Charmaz, 2003, p. 88). Processes such as dissociation and splitting make it impossible for some aspects of countertransference to be directly communicated. Participants may be unaware of some of the processes they engage in and may be unable to acknowledge/observe places of personal pathology that could negatively affect their patients. Engaging in interpretation and eventual conceptual analysis allowed raw

data to emerge into a picture of the ways survivor therapists struggle and accommodate to trauma-related reactions as well as the underlying unconscious forces involved in the struggle.

Participant interviews. Face-to-face semi-structured interviews with participants fostered an understanding of the ways surviving therapists experienced and used somatic sensations in the context of trauma work. As participants spoke about their experience, interesting trains of thought or emotional valence were noted and guided the process of questioning. The freedom of the semi-structured interviews allowed the surviving therapists to direct more of the interview and tell more of their own story as the expert (Osborn & Smith, 2003). Some questions and areas of exploration were generated from the data as the process of interviewing was occurring so as to allow further exploration of theoretical constructs that were emerging (see Appendix B). The interviewer's subjective experience was used in order to use include intersubjective experience as data.

With the subject's permission, interviews were audio recorded for later transcription. Once interviews were completed, recordings were transcribed and included aspects of the subject's tone, emotional quality, and inflection. Text was interpreted and emerging themes or codes were organized. The initial coding was done by coding each line of the interview data: giving a name to what was occurring, what was being thought, said, or taken for granted (Charmaz, 2003). The next step involved selecting the most frequent occurring codes to sort and organize the data (Charmaz, 2003). Quotes were arranged according to code, compared and contrasted, and categories were selected as processes emerged. Categories arose from codes and were broken into components, and memo writing added depth to each component; elaborating processes and revealing distinctions (Charmaz, 2003). Memos were written based on recognized patterns and narrative was used to elucidate these patterns. The researcher's subjective

experience was used as a way to add in what may have been communicated by participants in unconscious or non-verbal ways. By engaging in interpretation when covert meanings arose, theoretical explorations and hypotheses were able to be generated. The resulting data is a resource for surviving therapists interested in understanding how to make sense of their own reactions to their trauma patients.

Sampling. This study found three participants who had experienced an intentionally caused trauma and had experience working with trauma. Two patients disclosed discrete traumatic events that they had experienced and one declined to disclose the nature of her trauma. Participants connected discrete event traumas to earlier traumas that occurred in the context of their families of origin. All participants had at least ten years of experience working with trauma. Because participants were selected based on having experienced the phenomena in question, a criterion-based sampling strategy was used (Creswell, 2007). Due to geographic accessibility by the researcher, participants were all licensed psychologists practicing in the Northeast. All participants described themselves as having some tendency toward psychodynamic thinking, although they incorporated other integrative techniques and theoretical orientations into their work. There is a possibility that psychodynamically oriented therapists may be more adept at speaking about their countertransference as other theoretical orientations may not spend as much time attending to countertransference in supervision or consultation.

Recruitment of surviving therapists was done by sending out an electronic flyer for participation to a listserv for psychologists and psychology students (see Appendix C). Two participants were made aware of the study by committee members, and these participants were chosen based on their interest and their meeting the study's sample criterion. They were selected by their desire to participate in the study, experience with working with traumatized patients, and

experience with somatic sensations that occurred in their clinical work. All subjects identified as having a trauma that was caused by another human being. As interviews progressed it became clear that these traumas were associated with other earlier experiences of neglect or mistreatment.

Three participants were used for this study; however, phenomenological studies have been published with just one participant, and one to six individuals would have been considered an acceptable number of participants for the study (Creswell, 2007).

Ethical considerations and informed consent. Before conducting the research with participants, an application to conduct research with human subjects was submitted to Antioch University New England's Human Research Committee. The submission went through a full Institutional Review Board (IRB) review and the IRB application was approved on 9/28/2010.

All participants engaged in the study voluntarily, and were informed that they could discontinue participation in the study at any time. They were informed of the purpose of the study and were provided with an informed consent form (see appendix A). Ethically sound researchers protect the confidentiality of participants in that "the privacy of individuals will be protected in that the data they provide will be handled and reported in such a way that they cannot be associated with them personally" (Mertens, 2004, p. 333). Anonymity requires that no identifying material can be attached to the data, thus, protecting the participant's privacy. To adhere to these guidelines, all data was locked in a file maintained by the researcher who had sole access to the file. When completed, all identifying information was removed and managed in such a way that identities are unable to be discovered. As part of confidentiality, participants were informed that the researcher was lawfully required to report to authorities any reasonable suspicion of child, elder, or dependant abuse or injury of a participant (Mertens, 2004). Audio

files did not carry identifiable names of participants (see Appendix A).

Participants were given the contact information of the advisor and chair of the project in case they felt the need to speak with someone about questionable practices. In discussing different aspects of their own trauma histories and work with trauma victims, there was a high potential for participants to be triggered. At the end of each interview, time was allotted to process the interaction and discuss any emotions, memories, or somatic experiences that had arisen during the experience. Participants were encouraged to be attentive to their own reaction in the days and weeks after the interaction in case signs of triggering developed. Participants were made aware that referrals to mental health services would be made if requested; however, none of the participants requested referral services.

Data collection. As is typical of grounded theory studies, data was collected through semi-structured interview. Following participants' permission, interviews were audio recorded to aid in the overall fluidity of the interview and in establishing rapport (Osborn & Smith, 2003

Some questions about the participants' experiences with trauma patients and somatic reactions they may have had in session were asked, but flexibility was maintained in allowing the participant to have some freedom in which areas they chose to bring up, or as different areas of inquiry arose associatively. The effect of questioning was closely monitored (Osborne & Smith, 2003), so the researcher could either utilize some prompts or back away from material that may have caused the participant obvious distress. The average interview lasted an hour in duration, but the researcher allowed for digressions or abbreviations depending on how the material enfolded.

Chapter 4

Data Analysis and Hypothesis

Data analysis procedures. Following an ideographic model (Osborn & Smith, 2003), analysis of the interview data began by carefully reviewing each case before attempting to draw more general conclusions. First, transcriptions were read several times before interpretive, associative, and paraphrasing comments were placed in the left margins (Osborn & Smith, 2003). Interesting or remarkable material was commented on, including the language, body movements, eye contact, and affective tone of the participant. Next, emerging themes were documented in the right margin. The themes were consistently checked against what participants said in an ongoing attempt to remain as close to the psychological world of the participant as possible. They were elaborated on in memo form. Repeating patterns of thematic material throughout the cases were identified, as well as more novel themes that arose (Osborn & Smith, 2003).

Themes. The following themes emerged in speaking with surviving therapists about their trauma-related countertransferences: (a) regulation style, (b) sensation as cue, (c) identity, (d) metaphor of the journey, (e) metaphors of protection/aggression, (f) merger, and (g) the sweet humor of life. *A Descent into the Maelstrom* is used in order to further use metaphor in the process. The story is the researcher's association to the participants' material and is used to invoke imagery, affect, and symbolism in the reader. In this way it may help to fill in that which was present (and communicated unconsciously) but not manifested in the direct quotations. As surviving therapists may have developed adaptations to compensate for difficulty in using imagery and language to construct meaning for physical sensations, this, too, is an adaptation to compensate for that which may not have been able to be communicated via the verbal system.

Regulation

> As we approached the brink of the pit he let go his hold upon this, and made for the ring, from which, in the agony of his terror, he endeavored to force my hands, as it was not large enough to afford us both a secure grasp. I never felt deeper grief than when I saw him attempt this act—although I knew he was a madman when he did it—a raving maniac through sheer fright. I did not care, however, to contest the point with him. I knew it could make no difference whether either of us held on at all. (Poe, 1998, p. 38)

Regulation of the other to regulate the self. Participants recounted moments in therapy in which they experience intense affect or somatic reactivity. Often, both therapist and patient were, indeed, experiencing some kind of intense affect or traumatic sensation, and the therapist made a choice either to regulate the other to regulate the self, or to regulate the self to regulate the other. The participant who most verbalized his tendency to regulate the other to regulate himself considered it his job not to deal with anything that arose that was associated with his trauma in session: "I have to be alert to what is mine and not his. I don't have to, right it's my job and in fact it's critical that I have not worked through my mine, my experience in his therapy."

Later, he explains the early training he received in a family in which regulating his brother was key to avoiding his mother's rage:

> The countertransference is that I am supposed to take care of my brother. That's the, the dynamic part of it is about taking care of my brother who was really pretty destructive, self-destructive and destructive and avoiding my mom, her rage. So those like, that's the, so if I can do that and I'm effective then I am calm. Like in some ways I was absolutely raised to be a therapist. But then you have these moments when you have a client who is rejecting help in whatever form and they are not accepting it for whatever reason they are, were dealing with their resistance so I am not saying that, you know in a blaming way but in that moment my help is um ineffective maybe its unwanted whatever the interaction is so that invokes in me this impulse to kind of force the situation. So those like, so if I can do that and I'm effective than I am calm.

It appears that when regulating the other is essential to regulating one's self (consistent with one's belief about their role as therapist) impotent rage is more likely to occur with the patient's resistance to regulation. The impulse in the therapist to "force the situation" is potentially due to mounting internal anxiety that becomes threatening. The participant can be calm only when he has calmed the other. Krystal (1988) found guilt and anxiety reactions in certain patients when they gained control over bodily functions which they had thought were beyond their control. Some were afraid that there would be resulting punishment, possibly because of taking over the maternal function. Early mothering is experienced as "permission to live" (p. 177). The participant had learned that he could regulate himself via regulating his brother, thereby avoiding taking over the maternal function. Krystal observed that patients who would not self-soothe due to anxiety, would, if the soothing could be disavowed.

The patient had told the therapist of his suicide attempt after making an attempt, and he had spoken with the therapist on the phone and did not mention having suicidal ideation. The patient may have been operating masochistically, preserving his identity as a helpless victim while projecting his sadism into the therapist. The therapist noticed in the interview that he may have been holding the patient's aggression, which seemed to him to be just under the surface of the patient's expressed hopelessness. This aggression appeared as a somatic sensation of feeling "pouncy" or "curled up like a snake" that he was able to connect to earlier experiences of trauma in which his sense of feeling helpless or impotent induced a desire to attack.

Another participant acknowledged a high degree of lifetime dissociation and disconnection from her body. When working with trauma, she was more apt to feel less in her body than the other participant (and less when working with trauma patients), potentially because of her proclivity towards dissociation. This participant was also inclined to regulate the other to

regulate the self, explaining that:

> If I am tired, getting tired, bored, even though they are talking about a very important thing that is boring, that is not hitting some level that change is possible. So, I pay attention to that somatic sensation of… It's more like blood draining out of me. It is not like fatigue. It is more like blood draining out of me (laughs). I'll leave it at that metaphor. Um and when that happens, sometimes I'll refocus people verbally but usually, I'll refocus them somatically. So, and I have this little… I guess she is 13 now, who lives in either anxiety or dissociation all the time, pretty much all the time. And she is very smart to boot. So she has the mental gymnastics to play games and have interesting verbalizations but never make connections and never change. Which really is very tedious to me. Like I just am totally uninterested. So, I have her do jumping jacks. If she is not connected or if she is um making me work too hard to get the session started. I'll see her in the family context. But if she is not going to be in her body, in herself now as opposed to telling me a story about something which is not in the present moment. Experience is in the present moment. Stories are elsewhere.

If there is the feeling of her "blood draining out" of her she is inclined to get the patient's blood pumping. She brings the patient form "elsewhere" perhaps a dissociative or deadened space to a more vital place that is mirrored back to the therapist, renewing the sense of interest or vitality for the two. It may be the use of her own aggression (felt by the participant earlier as impotence) that induces her to enliven the other to enliven herself when she encounters dissociation as a type of perceived resistance. While the sensation is experienced as primarily somatic, imagery is associated with the sensation. "Blood draining out of me" is highly imagistic and sensory, and may signify that if the sensation is a projective identification, it may be in the process of becoming symbolized in the therapist through use of metaphor as in the referential process (Bucci, 2002).

Alternately, the experience of one's bodily fluid leaking out has the quality of the autistic-contiguous anxiety of disintegration (Ogden, 1989). The awareness of the patient not being present may trigger original anxiety associated with the emergent awareness of separateness, or perhaps the therapist is projectively identified with the patient's experience. Instituting a somatic experience (exercise) may restore the sensation of boundedness. It is a sense

of separation that is essential to the internal processing of a projective identification (Tansey & Burke, 1958). Interestingly, if a projective identification is felt to be a presence injected from the outside, autistic-contiguous anxiety may arise in response to traumatic anxiety related to feelings/memories of boundary intrusion.

Sometimes a patient who has needed to use deadness to survive may not be able to tolerate too much aliveness in the analyst (Eigen, 2004). From this standpoint, the participant may be repeatedly prematurely ejecting the dead self-state of the patient by getting her blood pumping, perhaps angered by her own "spirit" of bloodletting. If she is engaged in not tolerating/accepting the patient's transference and pushing it away (perhaps projecting back into the patient her own complimentary self-states), this may be a place where she is not surviving as a therapist.

Miller (1997) notes that while it may have been possible that:

> a sensitive child could have had parents who did not need to misuse him-parents who saw him as he really was, understood him, and tolerated and respected his feelings. Although such a child would develop a healthy sense of security and one could hardly expect that he could hardly take up the profession of psychotherapy; that he would cultivate and develop his sensitivity to others to the same extent as those whose parents used them to gratify their own needs; and that he would ever be able to understand sufficiently-without the basis of experience-what it means to "have killed" oneself. (p. 19)

The image/sensation of "blood running out of me" seems to imply this felt sense of having killed oneself.

However, Krystal (1988) writes that all too often therapists do not turn unsymbolized projective identifications into symbolic meaning for the patient which he sees as essential to

healing. The idea of intervening at the level of the body, versus the symbolic, may evidence a more symbiotic, regressive relationship involving both parties. Searles (1979) saw this as essential in some therapies. It is unclear, however, if intervening at the level of the body would eventually enable the use of symbolization.

Regulation of the self to regulate the other. One participant was more inclined than the others to regulate herself to regulate the other, explaining that when she self-soothes "I think it helps me and so I think it helps them." She noted that she:

> grew up on a farm and being around animals you have to be really aware of your own state if you're afraid you're more likely to get kicked. So I'm very aware of if I'm not comfortable I'm more likely to get in trouble so I do a lot sort of by taking care of myself and making sure that I'm calm. I feel okay and I've gotten to the point of I can say, Gee, I got to run to the bathroom just to make sure that I'm okay but I think probably more than most people I work with especially if I'm uncomfortable.

Her experience of "getting in trouble" with the animals if she was unable to regulate herself stands in contrast to the childhood of participants who had early experiences of regulating the other to regulate the self. Here, trouble does not occur when the other cannot be regulated, but when one cannot regulate oneself. This participant described her childhood trauma as relating to neglect more than the others. Before she developed a more nuanced ability to attune to her body and to care for herself in session, she became symptomatic. However, she notes that as she became more adept at noticing signs in her body (rubbing her hand together, doing some comforting action) that signal her to "pay attention," she no longer experiences the diarrhea that had plagued her in treating a highly aggressive patient. In fact, she finds herself performing a self-soothing activity, indicating that the soothing response is or has become an automatic one.

Both participants who voiced active strategies to regulate the other to regulate the self expressed more anger or annoyance at "being made ineffective at a patient's defenses." Each

participant, upon the onset of the interview, performed a type of self-comforting/self-other comforting activity. The participant most inclined to regulate the other to regulate the self offered a cup of tea to the researcher. The tea was declined. But, I was asked what kind of tea I would like and then handed a big cup. We both drank our cups. Despite not wanting the tea, the warmth on my hands was comforting. But I hadn't felt that I needed a warm cup to find a comfortable internal place to conduct the interview. I was struck by how one small act had invoked in me such an odd mix of comfort, appreciation, confusion, and annoyance. I was left feeling remnants of both the soothing and the coercion. Perhaps regulating the other to regulate the self contains within it some aspect of force related to the sense that one's psychic equilibrium is dependent on the other.

Another participant who self-regulated through the other started the interview by taking off her shoes and then rubbing hand lotion on her hands. She later mentioned that she listened through her skin. With this woman, I noticed feeling sort of dreamy or out of it in the beginning of the interview. It was hard to focus. As I listened back through the tape, as her voice became more and more intense, the more awakened and less dreamy I felt. As she spoke openly about feeling angry at people not being in their bodies, suddenly I entered more fully into mine. Her ending comments where that "we had fun once we got going." Throughout the interview, "fun" had been a theme. For most participants, laughter and fun were associated with aggression. I had felt the presence of a type of "drowned" spirit initially, feeling as if I were sinking into something that was draining the vitality out of me. This spirit seemed to move out of me as the participant's voice became more charged in discussing her irritation with patients.

Aggression was also used as a way to track the other's dissociation. Perhaps the interview had moved from a place where the dyad began dissociated and moved toward a fun or

non-dissociated place through some sort of creative act of aggression. Being in a patient's dissociation is a reminder of trauma, of "enduring" in a childlike way instead of living. It may be that because this participant spoke of her tendency to dissociate (the others did not), the act of being merged with another who is dissociated may create more anxiety than for someone who is less likely to dissociate. Within this theory, the act of coming up from dissociation, again and again, to a more vital, blood-pulsing fun ordeal may be a reliving of her personal journey.

The participant who had learned (via growing up with animals on a farm) to regulate the self to regulate the other did not seem to make an attempt to regulate me. Instead, she ordered and ate a meal (I did not) and waited until she was finished to begin the interview. She asked questions about my interest in doing the study; questions I felt may have been asked to put her at ease. It felt comforting to be in the presence of someone who took the liberty of comforting herself. I left the interview with the distinct impression that this person had a relationship of respect with herself and her body. However, it was not the sense once gets from, for instance, a dancer who seems gracefully and effortlessly in her body. Rather, it had the quality of someone who had learned the technique, step by step.

Therapists connected their regulation style to their childhoods. Whether one tended to regulate the self or regulate the self through the other depended on what they had deemed necessary to "stay out of trouble" in childhood. In regulate the other to regulate the self style, aggression at the patient was more common if they were unable or unwilling to be regulated by the therapist. My own experience was that not being given a choice to be soothed by the other induced feelings of confusion, irritation, and gratitude.

In *A Descent into the Maelstrom*, the brother had become "mad" from fright. He attempted to force his brother's hands into a ring, but the survivor knew they were both doomed.

The survivor felt grief at watching the brother attempt to survive in a frantic and forceful way. Fear, desperation, force, and grief were all tied together in the maelstrom. Participants who found themselves connected to another who would not or could not soothe themselves feared "trouble" would ensue. Here, trouble echoes the sense that one is connected to a sinking ship. Anger appeared as a protective response. The forcing of someone else's hands onto a "ring" (or a cup of tea) could point to feelings of rage and fear over one's dependence on an unreliable other. Freud (1933/1966) explained that trauma was associated with one's estimation of helplessness in a situation and a corresponding surrender to this helplessness. The forcing of soothing, of the ring, and of being in one's body could also signify an unrelenting attempt to prohibit the patient from surrender and return to a traumatized state.

Sensation as cue.

> I have already described the unnatural curiosity which had taken the place of my original terrors. It appeared to grow upon me as I drew nearer and nearer to my dreadful doom. I now began to watch, with a strange interest, the numerous things that floated in our company. (Poe, 1998, p. 40)

None of the participants ascribed to the construct of somatic countertransference or a somatic projection identification, although all described themselves as somewhat psychodynamic in orientation. Rather, they saw it as "somatic awareness" or "diffuse arousal" or "reactivity." How participants worked with sensations seemed to be related to their tendency to regulate self to regulate other or regulate the other to regulate self orientation.

Both participants who had proclivities to regulate the other to regulate the self had very specific sets of sensations for which they had developed language. They had a type of familiarity with their body metaphor, implying that they had languaged whatever subsymbolic experience

they were repeatedly registering. In Bollas's (1992) terms, these metaphors may have been connected to the spirits that were internally awakened by their patient's spirits.

One participant did not possess this type of metaphor relationship to sensation. She spontaneously spoke about the difficulty she had historically in supervision, where she was asked to use words to express what was occurring for her. She had detected in the field what felt like a privileging of imagistic thinking over a sensory channel of understanding. She noted:

> The other thing that's hard for me is I don't get visual images. So like the only way I can—memories come up for me is sensory body memories so I don't get visual images and I don't um in terms of like I've worked with therapists that are really good at saying well that brings up this image for me well what it brings up for me for me is a package of feelings well at least initially maybe a little harder to convey in a way that feels sort of hard to define. I think in therapy visual image is much more accepted as a valid experience. You can talk about it, bring it up and all of that is fairly familiar ground but body images which in some way are just as valuable and in some ways even more so when you're working... I think I'm especially good with working with people with trauma and early childhood neglect because they don't have the words. And I think because that's been close to my experience I can sort of just tease out ways of talking about sensation and longing and, and kind of that diffuse fear in a way that I think is helpful. For me anyway all of that is much more of a sensory experience.

This participant was particularly keen at monitoring her sensations, regulating herself, and was the most likely to use the sensations as cues that something may be occurring in the room that she was not conscious of. She explained that somatic sensation and the body are also images, evidence that the two had not been split in her own mind.

Another participant had a sense of feeling "coiled up like a snake" when protective/aggressive urges were coming up for him. Here again is imagery that has been associated with a repeated somatic sensation. Either the therapist is using metaphor and symbolic processing to understand the subsymbolic, or the sensation was a package of sensation and symbolic information that included both channels. He spoke of his own fear of snakes, that he can hold one without anxiety, but that "seeing them slithering" on television was much more

activating. He described feeling made impotent by a patient's defenses. A patient had called him during a crisis and minimized it, after the fact revealing he had meant to kill himself after the phone call. The patient did not acknowledge his level of distress. However, it is worth further exploration to determine if the patient may have unconsciously been attempting to regulate the other (therapist) to regulate his self by not disclosing suicidal ideation. If the patient sensed that the therapist would become activated in the territory of suicidality, not disclosing his suicidal intent may have been an attempt to coerce the therapist into a state of calm. Later, the participant suspected unconscious aggression in the withholding. As stated earlier, coercion and aggression may be present when it is felt that the one's psychic state is dependent on the other's regulation.

The participant described a feeling of wanting to curl up (associated with a traumatic memory of being knocked down and terrorized by a bully in elementary school) and of wanting to be kind of "pouncy" when there is a feeling of impotence. Here, the spirits of his past seem to be somatically linked and evoked by the patient's material. Later, the patient discovered an intense aggression he had beneath the surface of the depressive affect to kill himself. While he had not made the connection until reflecting upon it in the interview, the therapist realized it may be that his sensory/imagistic experience was representative of the patient's own unconscious aggressive impulse.

Another participant explained that certain patients:

> annoy the hell out of me. In 30 years, they are the first people I consider to annoy the hell out of me and I just, you know… And I just and I need to go deeper place to work from so I'm not justifying my annoyance. But um my aggravation is so unusual for me and it is so distinct, um. And um what it's tracking is their hostility level. So, they're nice and depressed and uncertain (mimics) and it's all a control strategy. It is just control strategy. And I get annoyed with people who run control strategies on me while saying they're not. So, this… really this irritability which is very somatic, very somatic like I'm really short-tempered with them. And I'm not sure that I will ever completely resolve that. I don't know a calm way to shove them into awareness because they are so unconscious of how hostile they are. They perceive themselves as victims. But you

> know you just better watch your back because they'll cut you the minute you just turn your back.

While the participant's irritation is useful in that it tracks unacknowledged aggression in the patient, it also arises in the context of feeling controlled. However, it is unclear how one would determine whether the patient's attempts to control aggression may be an unconscious attempt to regulate the therapist to regulate the self (theoretically an effort to control the other, or "control strategy.")

Another participant described a somatic experience that signaled to her that there was an opening for change to occur. The experience was named "hopping up and down" and was associated with a somatic sensation of vitality. She contrasted this with her experience of feeling the "blood draining out of me." Both physical sensations had become a pattern experienced frequently enough to have been linked to aspects of the therapeutic interaction. Similarly, "coiled up like a snake," the image/sensation called upon by another participant, also seems double-sided with meaning. A snake both coils when it must strike (often out of an attempt to protect itself), and it also coils to regulate its own heat in a protective, self-sustaining stance. Naturally, aggression and protection are indeed linked. Harris speaks of moments of therapeutic aggression that "bespeak the ruthlessness of survival, but it is an aggression also recruited for care and containment of another" (Harris, 2006, p. 551).

If one felt the other as draining out one's blood, they may strike the other in order to stop the bloodletting. But therapy is a relationship. As all participants knew: regulate one part and the other part becomes regulated. Thus, one could also picture a scenario in which one's aggression in response to the other's dissociation would be an attempt to protect both parties...from something life-draining and stagnant. Alternately, the "hopping up and down" sensation may be a signal that something mutually unrecognized and unconscious is moving toward symbolization.

The participant who spoke most about her body as an instrument of cuing had the least access to imagery associated with sensation and with traumatic memories. Instead, she had become incredibly adept at forming a complex coding system, with different sensations pointing to different elements in the room:

> Let's see if I can identify a pattern. The chest stuff is much more apt to be sadness and grief um and the stomach stuff probably more fear and sexual stuff anything down there you've got that possibility [meaning the sexual organs]. It's strange I actually have to debate it's strange I have to debate is this threatening or something else. I actually do have to debate is this um threatening or sometimes I have to debate in my mind which set of sensations it is.

Here, she acknowledges the difficult to tease out feelings of sexuality and fear. One study found that female trauma therapists were measured for arousal, and found high levels for women in therapy sessions with rape content (Suschinsky & Lalamiere, 2010). The writers concluded that women's bodies were likely preparing for rape, attempting to decrease the likelihood of injury. The research did not differentiate women who had a trauma history and those that did not. Nonetheless, it may explain the confusion of fear and arousal. The participant also discussed the ways that her veteran patients may respond to their own fear, arousal, and rage by becoming seductive:

> Most of the time it's a matter of finding a way for me to be comfortable in a room and sort of then know how I'm directing the question and sort of what I'm feeling especially when I don't know the person I'm unlikely to say anything about my experience of it but I might ask--well, I might ask directly in terms of are things o.k. sexually at home I assess it-or is there a problem. It leads to that sort of question.

The sensation is a *reminder* to ask "that sort of question." Sexuality is not being kept in mind, it may be present, and the body cues the mind in to what is unconsciously being picked up within the session. She explains:

> It tends to be that kind of thing when I think I'm doing one thing and all of a sudden my body starts doing something different and it's that sort of surprise then I have to wake up and realize that whatever I'm sensing consciously is not the whole story.

The whole story was hard to come by. When asked about somatic sensation as perhaps representing projective identification, participants spoke of the importance of not being too intellectual. One noted that he had "disconnected from the emotion and the insight." However, it is clear that they were able to use affect as a signal of something occurring within themselves and the room and therapists used this signal to different degrees to inform intervention. Participants had maintained enough wonder about their reactions that they had begun to rely on them diagnostically to inform intervention.

In *A Descent into a Maelstrom,* the "unnatural curiosity" the narrator found in himself ended up saving him. After looking at the things that surrounded him he used what he understood about the maelstrom's pull on objects to choose a barrel to cling to (its shape allowed him to not get sucked in to the center of the maelstrom). The brother, desperate and maddened by fear, drowned on the ship. Curiosity allowed the narrator to know what was floating in his company and to use this company to buoy himself. In the same way, participants used their body to understand what was floating in the room and inside of themselves. Thus, curiosity may counter helplessness and the ushering in of surrender and trauma.

Identity: "Attachment to Trauma" and Role

> I was borne violently into the channel of the Ström, and in a few minutes was hurried down the coast into the 'grounds' of the fishermen. A boat picked me up—exhausted from fatigue—and (now that the danger was removed) speechless from the memory of its horror. Those who drew me on board were my old mates and daily companions—but they knew me no more than they would have known a traveller from the spirit-land. My hair which had been raven-black the day before, was as white as you see it now. (Poe, 1998, p. 43)

Therapists differed in what they constructed as their identity as a therapist, and these roles seemed to impact the ways they utilized their aggression in session, how they regulated themselves, and when. The following roles or identities occurred among participants, and interestingly, within themselves. Identities included the victim/attached to trauma, the mock therapist, and the embodied therapist.

Victim. The victim-therapist identity seemed to arise within the context of high conflict as a:

> kind of protecting myself from ultimately I think it's from my anxiety like, there is an open conflict going on and my inclination is to want to shield myself from it. To not be caught in my parent's argument for example um or to not get caught in the shrapnel when my mother was going after my brother you know when I'd just as soon you know, duck. Um and as soon as I realized that's happening I am able to engage.

The therapist is able to move from a protective stance of anxiety towards a place of engagement by appealing to his therapist role:

> So once I overcome that, once I have realized that I sort of got my hand on the ejection button, then I'm ok. Then it's like hey get back in there this is your job, they pay for this, they deserve this, you like doing this and so I am able to sort of my ask myself what's happening that you know, what is happening for her at this moment that she is being so hostile to him.

Anxiety experienced as an internal threat is soothed by an appeal to the therapist identity (this is your job...), a movement away from the experience of the child, and a corresponding orbiting around the other (what is happening for her at this moment.) The reminder that the context is a paid position and a job that one enjoys is a reminder that one has entered into a situation on his own accord instead of having been pressed into it either as a child or victim. The sense of choice, of being the master of one's own feelings, moves away from the sense of surrender (after the appraisal of helplessness) that ushers in the traumatic process (Krystal, 1997).

Another participant saw attempts to ignore the body or to endure a session as a victimized position. She describes:

> Believing that it is not safe to be in my body which my history would tell me is going to become a self fulfilling prophecy. I'm not saying this very well. Um, it is like I've taken up the martial arts, which is like the most terrifying (laughs) possibility in my life as being in a place of violence. Like I am going to be there in this place with violence and I I'm and I don't know if I can say this here. I'm realizing that I can go there in an effortful way in which case I'm already reliving my history because I'm putting out effort. It is implied that there is something that I must cope with defend against manage and survive. Or I can go there in 2010 because I am in the dojo. All right, go there and master something or not have a flashback, or I can go there because I'm in the dojo. Two very different states. One is in my personality, my defense structure, my history, hoping that I'm not reliving it which means I am reliving it.

One participant's tendency to sabotage his caretaking efforts (scheduling bodywork before a full day of sitting) allowed him to become conscious of how difficult it is for people to be in emotional or physical pain. The sabotaging of self-care efforts could relate to the aforementioned conflict around taking over the mothering function, which induces the fear of re-experiencing the traumatic moment. Interestingly, having bodywork done by the other would be a situation that easily could be disavowed. For instance, one could potentially avoid fear over self-soothing with the rationale that it is the other, and not the self, that is performing the soothing activity.

The concept of enduring, developed in the battleground of trauma and survival, was not simply stamped out by participants. It had a curious lure and could be slipped back into.

> (Sighhhhs.) Well there are times, with simple stuff like there are times when I just want to be sitting anymore and we sit a long time (laughs). Um you know like so there are times when I really overscheduled schedule myself and every Thursday I see someone who does body work in the morning and then I will have like five people in a row Friday afternoon and I am like that was you know that was dumb, what good was all that body work I am sitting static for all those hours.

Sitting static is reminiscent of enduring (an experience participants connect to victimhood) and the unconscious seems to lead the participant to sabotage his efforts at self-care. This may

indicate an attachment to the victim identity. One must sit without movement (without defense) and endure without self-care. Another participant explained that:

> A lot of trauma folks and myself included, I have been an enormous victim. For me and for years I didn't know I had it. It was unconscious. Now, I know I got it. But trauma people have a great sense of having been victimized and to help them come out of the victimization-not a sense of mastery. It is the sense… I don't have the words for this but there is a sense of joy. It is a very advanced state of where you get the blessing of the ordeal. And it is not at all through the head because people had a great warning, whatever. But there comes a point where I don't know how to say it what they really are… There is no chip on their shoulder for what is done to them. There is no self blame for what was done to them because that is always there, too.

Here, too is the sense of sabotaging one's own caretaking efforts:

> and there are times as I evolved I will misuse my body thinking it is a step forward and it is just a learning on how much suppressed rage and how much suppressed self sabotage I have. So, I have the experience of self sabotage. What a great experience. I can see how I do it. Wow. I may do it 45 times to really get that pattern down. So, I may put my body through a lot but as long as I have no judgment of it and I'm really open to the experience. Why would I regret anything? I can fuck myself up a lot but my heart is open. I'm like wow. Look at what I'm doing. My choice. So, yeah. I mean, so, it's all good.

The sense of the self choosing arises again as a theme. It echoes the "hey, you like doing this, you get paid for doing this..." appeal to the therapist-self. It may be that actively moving one's mind from a victim identity to a place of self-choice (and in these cases conscious self-sabotage) is a moving away from the attachment to trauma that is described by one participant as inherent to healing. The sense of choosing to go into the therapy room to work with a patient who may be acting sadistically is the difference between trauma enactment and chosen profession.

The mock-therapist. The mock-therapist appeared in the context of aggression. Here, a mock-journal was referenced by a participant. It had mock articles about "smack therapy" and "laughter therapy" where patients are laughed at. Essentially, the journal was mocking the

therapist's aggressive impulses. Two participants who had regulate-other to regulate-self orientations laughed during content that was charged with aggression at patients. Participants had constructs related to "needing to find a deeper place to work from" with patients that aggravated them. Another said that it was imperative that he "not get *caught"* acting the aggression out. An apt slip, since it is improbable that a therapist would be capable of never acting on their aggression. Winnicott (1949) felt that the patient can be helped by the analyst's show of hate or madness.

The identity of the mock-therapist shows the flip-side image of the idealized therapist. The mock journal is funny because it is recognizable; in fact, the participant likened it to his own familiar impulse to shake a patient like a parent "wants to shake a child." The laughter at the aggression throughout interviews suggests a deep desire to discharge the aggression and to make something creative from it. And while every participant spoke about their aggression, no one spoke directly to the healing uses of aggression, although it seemed apparent within the context: the "fun ordeal" of forcing a dissociative or avoidant teen into her body with push-ups, for example, or why aggression seemed to be the thing that caused them to experience things somatically.

Thus, participants were aware both that they were being controlled and rendered helpless, and, at the same time, had picked up something of the patient's unconscious aggression. Many spoke about patients' disavowed or unconscious aggression.

The being vs. thinking/embodied therapist. All therapists spoke of intellectualization, words, and theory as being farther away from the heart of the matter in the clinical endeavor. One participant said that it was "hard to describe because I am never flip about my work." Essentially, the act of putting into words what occurred in the session, "body to body" was felt to

be not honoring the depth of whatever was occurring.

Participants found *thinking* to be secondary in many cases. That:

> It has been surprising really as we talk I realized I work really primarily through my body. Now, as much as years ago, I'm always aware of my skin. It is always what listens- not my ears, odd thing. Um, but now, so much of my whole body that listens and my head thinks a small amount but so it has called my attention to how deeply into my body I descended to enjoy this work more.

Descent again refers to an awareness of some deeper level, and here it accompanies enjoyment. It echoes Winnicott's (1960) "true-self" that "comes from the aliveness of the body tissues and the working of the body functions, including the heart's action and breathing" (p. 148).

Often, the theme of patients thinking too much, of *doing* the act of therapy rather than experiencing a grounded, full 'holistic" experience of being with another person, paralleled the therapist's hesitancy to become too intellectual about their own work. There had been little investment in understanding somatic sensation in terms of countertransference or projective identification. What was much more central for participants was what they *did* with sensation. Every participant repeatedly used phrases such as "it's hard to put into words" and "it's difficult to explain." They relied on imagery and metaphor or stayed with the language of the body. The participant who explained that she did not have access to imagery, felt it an asset to be able to struggle with patients who do not have words to describe experience—she could use the language of the body. At times, she would disclose to a patient a bodily sensation ("that makes my heart hurt"). Bollas (1992) found it:

> indispensible in utilizing countertransference states even though in doing so I am not fully conscious of what my internal state means. I am now referring to those sorts of feelings an analyst has in working with a patient which can be described as hunches or more accurately as senses. As I am particularly concerned to work with the emotional

> core of the patient in each session, it is important to be able to signify what amidst the patient's associations seem to announce true self activity. By true self activity I mean the part of the person's psychical movement in a session which seems to work from the core of the self. (p. 10)

These implicit clinical abilities imply a deeply learned process which is, thus, subsymbolic (and difficult to represent in language; Bucci, 2002).

One participant discussed a patient who was:

> not in her body She is sitting, mental construct. She is saying things that I know are meaningless to her. "Oh, school is going fine" (mimics) or "my mother wasn't listening to me." Well, were you talking to her? Connect. Tell me something. If I can't feel the realness of what someone says and I feel it in my body, I'm not going to have some intellectual discussion about how she talks to her mother. Do it now. (urgent, impatient). If I can't feel you connected with what you are saying, why would I chat about it? In sessions I wait until I can feel something. I just like… It's like a whale and there would be gills and they filter you out the planktons. Like I'm kind of like on this cruise in the waters with my gills, waiting for something that's tasty, that somebody means.

In this statement, the participant is using both somatic sensation and imagery to detect when there is true-self activity. It was as if participants understood the language of what was occurring and did not return to models or theory to translate. It just didn't seem relevant, somehow. For instance:

> It is a matter of receiving me as I am, (clears throat) all of me. That puts me in a more unified state with my body. It's affected doing therapy because therapy is all about thinking and about constructs. The genograms, take life histories, make meaning out of life histories; people are investing in their life histories. They think they are important. We all think our life history is important. They aren't. They are important to be able to say them out loud and stay in the present. That's about it, all right? They do not predetermine us. So, kind of finding the meaning of being in my body versus being in separation in my personality, in my story, in my mental realm. Understanding that meaning has allowed me to work differently with people who are very invested in their pain and suffering.

Working differently with those invested in pain could also be present in the participant

who laughed with the patient who was bringing a roll of toilet paper into the woods in a mission to kill himself. Trauma is overwhelming sensation that cannot be discharged or mastered (Freud, 1933/1966). Laughter and aggression are ways of discharging sensation. Laughing at toilet paper is not a reliving of trauma—for the patient or the therapist. It is a *different* way of being.

The survivor in *A Descent into the Maelstrom* speaks of the beauty of the maelstrom— there was some awe about the power of the elements and the insignificance of the individual. But it seems that there is something else—the identity of being, or the true-self that is not a mental construct. It is as if thinking about countertransference as a sole indication of one's history is a part of the victim identity and does not allow one to go into a certain depth with patients. The survivor's hair had turned white in the maelstrom, and something in him had changed. There is an insignificance of the individual in trauma, or as one participant said it is "not a personal statement." While participants seemed to be involved in an active process of becoming aware of their victim identity, they had also learned that their body could signal what moved them—and their patients—to true-self territory.

Metaphor of the Journey

> After a little while I became possessed with the keenest curiosity about the whirl itself. I positively felt a wish to explore its depths, even at the sacrifice I was going to make; and my principal grief was that I should never be able to tell my old companions on shore about the mysteries I should see. These, no doubt, were singular fancies to occupy a man's mind in such extremity - and I have often thought since, that the revolutions of the boat around the pool might have rendered me a little light-headed. (Poe, 1998, p. 37)

Participants used words such as "descent," "melee," "muck," and "maelstrom," to describe the experience of entering into the work of trauma. One participant discussed her work with a

reactive attachment-disordered girl who was kicking and hitting the participant. The participant described feeling extremely *in* her body and extremely in control. In one "seamless" moment that occurred without "worrying if it was the right thing to do," the therapist took the spit that the girl had spit onto her face "and I just took that spit and I put it right on her cheek and, um, and stayed with her in her meltdown around that." She noted that after the session the girl had completely come into her body, something she had never seen before. The therapist described the session as "horrendous" and "amazing."

The participant:

> had found the places where I could build a bridge and help her re-orient. Um and the other thing I noticed that was that having gone through the descent into a complete melee, I mean a complete maelstrom, she was normal. I had a non-symptomatic kid. She conversed. Her affect was appropriate which it never is with her. She is always in some somatic form and having entrusted her body with me and me trusting my body to meet her in that language, and then bringing it back to a narrative level at the end.

Melee is defined as a "confused fight; especially, a hand-to-hand fight among several people" (Meriam-Webster, 1995, p. 338). The French term refers to any "agitated tangle," "confused tangle," or "unordered combat" (p. 338). The patient was confused about where she began and the therapist ended, and she was projecting her aggression as she was enacting it. Maelstrom is defined as a powerful whirlpool with currents and crosswinds (p. 326)

Having been through the descent, into the melee or maelstrom with the patient, it was brought back to a narrative *level.* There is a sense of coming back up from the depths, as the narrator in Poe's *A Descent into the Maelstrom* described, of having lived through the maelstrom and coming back to tell the story (within a story.) There is also a willingness to go back into the depths.

Another participant:

> Couldn't imagine being drawn to work with them if you haven't had the experience. And so I think it would be tough just to value their experience if you didn't know it was valuable for me to walk through this it would be hard to know it would be valuable for someone to walk through this kind of muck. So I think it--for me, a lot--especially the long term people knowing it will get better and there's a resolution and all of that it's a big part of what I have to offer. And I don't think you can know that on a gut-level without having covered that ground yourself... So in that way I would say yes you have to have had the experience.

Here, she walks *through* the muck to get to some sort of resolution. She can guide patients through the muck (and is interested in doing so) because she has lived to tell the tale, as did Poe's narrator. The "muck" may be the projective processes occurring within the session, the entanglement of both parties internal experiences, and then an ability to join at the "level of narrative."

Participants spoke about learning to "let things pass through" them differently, to acknowledge that some patients would come in threatening and aggressive, and to trust themselves to act spontaneously as all having been a part of their journey as developing therapists. The survivor in *A Descent into the Maelstrom* went through terror and helplessness before he arrived at a desire to "explore the depths" and understand the mysteries of the maelstrom. Participants described a parallel experience in working with patients: experiencing the melee and peering into its depths, becoming lightheaded and overcome, and arriving at a more observational, curious stance.

Mine/Yours Merger

> There was another circumstance which tended to restore my self-possession; and this was the cessation of the wind, which could not reach us in our present situation—for, as you saw yourself, the belt of surf is considerably lower than the general bed of the ocean,

> and this latter now towered above us, a high, black, mountainous ridge. If you have never been at sea in a heavy gale, you can form no idea of the confusion of mind occasioned by the wind and spray together. They blind, deafen, and strangle you, and take away all power of action or reflection. (Poe, 1998, p. 38)

The construct of the melee, or confused tangle, was a leitmotif in all of the interviews. Repeatedly, participants wondered "is this mine, or theirs?" and that for two of them, determining what was theirs or the patient's feeling or experience was evidence of an experience of projection, confusion, or merger. One's identity as therapist (i.e., "it is absolutely crucial that I don't work with mine in their session") seemed to ignite the desire to determine the boundary between self-and-other. In the containment–separateness phase, the therapist gains observational capacity by regaining a sense of separateness (Tansy & Burke, 1958). One way in which this is achieved is through super-ego suspension (Fleiss, 1942). Searles (1979) found that only after the analyst had worked through the guilt that erupts around the construct of "dedicated-physician selflessness," a reaction against negative feelings towards the patient, could they enter into a "therapeutic symbiosis" (p. 87). Here there is no longer a need for the concept of self and a therapeutic merger can occur as both therapist and patient emotions are no longer experienced as threatening.

Interestingly, the participant who was least concerned with determining what was "mine or theirs" was the therapist who used the term "melee" and "maelstrom," and saw going into the maelstrom as perhaps linked to her role as therapist. She was the only participant who mentioned the belief that therapists all do the work for themselves "or else I don't know who we are talking to if it isn't ourselves." She described a profound sense of separateness and embodiment that occurred during a clinical "maelstrom," ending with her marking "toe-to-toe" the boundary of

patient and therapist, literally giving the patient back a piece of her ejected self by wiping the patient's spit back on the patient's face.

One participant consciously stopped mirroring the patient's body language if she found her own history getting "kicked up." In essence, mirroring is an unconscious attunement that moves closer to merger. Another participant called upon his therapist role when he felt it was "his" that was getting stirred in the session.

All participants gave examples of initially thinking it was "theirs" and discovered ways in which they may have been experiencing what the patient was experiencing. However, in Poe's *A Descent into the Maelstrom*, one brother drowned and the other went mad from the horror. In order to "bring it back to the narrative level" from a primitive space, one may need to be "in" one's body, not feeling as if they are going to be re-traumatized. It is an interesting question whether certain projective identifications, or the experience of feeling as if something foreign has been injected into the self, may reactivate traumatic sensations/identities/memories or anxieties associated with the autistic-contiguous position (Ogden, 1989).

Metaphors of Aggression/Protection

"It was mere instinct that prompted me to do this—which was undoubtedly the very best thing I could have done—for I was too much flurried to think" (Poe, 1998, p. 35).

Participants did not intentionally speak of their aggression as having a role in the therapy. Although one woman noticed her aggravation or annoyance as a cue that the patient is not in their body (and thus had them do push-ups, etc.), this was not verbalized as the therapist's use of aggression. Neither, in fact, was the act of consciously interrupting mirroring to attend to one's own body or ground oneself.

Aggression was something that signaled to "find a deeper place to work from" or to be

careful not to act out, etc. The image/metaphor of feeling "coiled up like a snake" contains in it an aspect both of aggression and protection. The therapist interrupting mirroring, or having the patient do jumping jacks, or regulating the other to regulate the self could all be seen as protective aggression. It is a cutting off of the melee, or merger, an institution of boundary. Interestingly, the participant who felt "coiled up like a snake" when being manipulated or made impotent by a patient was quite afraid of snakes. The difficulty with being afraid of one's aggression, or deeply conflicted about it, is that aggression is often a protective response. Before one participant was able to use aggression to turn away from the patient to protect herself, she would have diarrhea after seeing a violent and rageful patient. Now, she explains she can just "let things pass through me." Consistent with Davies and Frawley's (1994) thinking that surviving therapists may have difficulty with their identifications with abusers (and, thus, their being able to be bad objects to their patients), it seems that this could inhibit therapists from receiving and processing certain projective identifications. The body metaphors participants had developed "hopping up and down," "blood draining out of me," and "coiled up like a snake" may all hint at "spirits" (Bollas, 1992) that inhabit the therapist, tapped on by different aspects of patients' own spirits.

In *A Descent into the Maelstrom*, the "mad" brother furiously attempts to save his brother and himself in a fury of fear and desperation, the survivor journeys to curiosity and eventual survival/victimhood, and the maelstrom fascinates, destroys, and confuses. To some degree, these spirits were present in somatic sensations that seemed to contain elements of protection, survival, fear, vitality, chaos, and aggression.

The Sweet Humor of Life

Never shall I forget the sensations of awe, horror, and admiration with which I gazed

> about me. The boat appeared to be hanging, as if by magic, midway down, upon the interior surface of a funnel vast in circumference, prodigious in depth, and whose perfectly smooth sides might have been mistaken for ebony, but for the bewildering rapidity with which they spun around, and for the gleaming and ghastly radiance they shot forth, as the rays of the full moon, from that circular rift amid the clouds which I have already described, streamed in a flood of golden glory along the black walls, and far away down into the inmost recesses of the abyss. (Poe, 1998, p. 39)

One participant described a moment in which she was surprised by her desire to laugh in session. A man had been telling her of his suicide plan, which included taking toilet paper with him into the forest where he would complete the suicide. The laughter was at the irony that of course he wouldn't need toilet paper after he was dead and that his mind was still preoccupied with cleaning himself. Perhaps this is what one participant refers to as "the blessing of the ordeal" or the "sweet humor of life." Laughter was present in interviews when participants spoke of their aggression. They laughed at describing being "pissed off" or aggravated. The image of the mock journal and "laugh therapy" is a leitmotif. It may be that the aggression is what fuels not "knowing a gentle way to force them into awareness." The anger at feeling the blood draining from one's veins, or feeling the strength of a patient's resistance, is that participants had made it out of the melee, towards life, and that perhaps the patient had not.

One participant talked about a transformative moment when he laughed when thinking about confronting the bully that traumatized him. Perhaps the laughter is the acceptance of aggression, a type of freedom that comes with acceptance:

> But it is occurring to me that for me, I really can't have joy without my body. Joy is not a bliss state. I mean I can do energetic bliss but it is like eating imaginary food. No, I want a bite of the vegetarian burger. I want to taste it. I don't want to (sniffs) mentally enjoy it. So you f… Why not be happy? It's my life. Why shouldn't I be happy? And life is

> mediated through the body. I don't mean the heart beat. I mean life is mediated through sensation. And we have a sense… not sensations, but sensory awareness.

The participant who laughed at the patient's story of toilet paper had initially had diarrhea with her first violent, aggressive patient. This early patient helped her to understand that it was possible that a patient could come in hostile and threatening. She later learned to "let things run through me" so that symptoms did not develop, and ended her interview with the tale of laughing about toilet paper accompanying a patient in his plan to kill himself. Here is the orientation towards life—the feeling that one has made it out of the woods.

Participants provided a glimpse of what their journeys into the maelstrom entailed. Just as *A Descent into the Maelstrom* is a story-within-a-story, participants illustrated the ways their own stories and spirits were invoked in working with patients. Often, their bodies alerted them that some aspect of their history was being activated, although the ways participants used sensations to inform their work took place in a sub-symbolic domain that was difficult for them to break down into language. They acknowledged their histories as drawing them towards trauma, allowing them to have a depth of experiencing and understanding that at times proved difficult. They were often ambivalent about soothing themselves, discharging affect, and using aggression to protect or to create although there were ways that they did in fact do all of these things. Participants spoke of the value of going into the muck with patients and truly *knowing* the value in the act. Trusting the body, and one's self, to venture into the projective muck seemed critical. Participants had an awareness of the "sweet humor of life" that seemed to venture into the darkest of territories: dissociation, death, suicide, and aggression. They would go into the forest with their patients, but not without a roll of toilet paper. They had come to understand the other side of the maelstrom, and while at times their patience seemed to grow thin (they were awaiting their patients to join them), they had the "sense of choosing." This was their job, they

told me. They had chosen to return to the maelstrom, to talk with me, and to enter into a profession where they would be exposed to trauma stimuli all the time. They were *that* sure of the value of going through the muck. They had come to trust their body and even to rely on it to be present and alive with patients and saw doing so as a move away from traumatized/victimized position. Their spirits seemed to have similar shapes. Participants struggled with their aggressive feelings towards patients, their self-protective responses, and their merging with patients. Some described having no access to words and using their body and emotional experience as an alternative channel and others saw describing their work in words as becoming "glib" about it. All indicated different "levels" or depths of experiencing with patients having to do with words, emotions, and bodily experiences.

Chapter 5

Discussion

> The result was precisely what I hoped it might be. As it is myself who now tell you this tale—as you see that I did escape—and as you are already in possession of the mode in which this escape was effected, and must therefore anticipate all that I have farther to say—I will bring my story quickly to conclusion. It might have been an hour, or thereabouts, after my quitting the smack, when, having descended to a vast distance beneath me, it made three or four wild gyrations in rapid succession and, bearing my loved brother with it, plunged headlong, at once and for ever, into the chaos of foam below. The barrel to which I was attached sunk very little further than half the distance between the bottom of the gulf and the spot at which I leaped overboard before a great change took place in the character of the whirlpool. The slope of the sides of the vast funnel became momently less and less steep. The gyrations of the whirl grew, gradually, less and less violent. By degrees, the froth and the rainbow disappeared, and the bottom of the gulf seemed slowly to uprise. The sky was clear, the winds had gone down, and the full moon was setting radiantly in the west, when I found myself on the surface of the ocean, in full view of the shores of Lofoden, and above the spot where the pool of the Moskoe-strom had been. (Poe, 1998, p. 43)

Participants did not seem to have global inability to use symbolic imagery. In fact, they had formed their own imagistic and metaphoric language of their bodies and used their metaphors as complex cues. The referential process had indeed left its trace (Bucci, 2002). It did not appear that there had been difficulty in affect use as a signal, and that often this signal was that something was occurring in session that was not being verbalized or acknowledged by the

patient and therapist. Often, this was communicated back to the patient but through non-verbal channels. The therapist asking the patient to do jumping jacks signified a deadness or conformity in the patient and a corresponding annoyance in the therapist. It is not clear; however, if there is some implicit wisdom in such interventions or if they are better understood as enactments. In *A Descent into the Maelstrom*, the reader never knows why the survivor took the young boy back to witness the spot where the maelstrom had occurred. The reader senses there is something important to the man about the journey, about having a witness. If patients benefit from having their emotional schemas activated and reflecting upon such activation then (as one participant explained), there is a gift that therapists gain from the act of doing therapy, of going down through the cycles of activation, or projective-identification, or muck wading, or spirit-housing.

If surviving therapists can bear the experience, contain it, and reflect on it, then likely healing occurs for both parties. This may be evidenced by the somatic/image/metaphors survivor therapists had developed relationships with. They spoke with a sense of ownership ("oh, I call that my such-and-such feeling") and familiarity that their clinical experience had fostered. Familiarity enabled therapists to use their sensation or spirits without necessarily having access to the who or what of the spirit. Spirits also heightened the risk that action would be used to eject the countertransferential experience, and some therapists had developed ways of using their somatic metaphors ("I feel curled up like a snake.") to lead them back to their role as therapist ("this is your job, you enjoy this.").

Participants had developed a complex system of metaphor, imagery, and body sensation. Often, it was not simply a place of regression to the somatic. Symbolic and metaphoric processing was used with sensation to begin to tell a more complex story. Participants often intervened using either the body or the language of the body. However, it is unclear if this stems

from an understanding that the patient's capacity remains in this domain and that this would eventually evolve into a more symbolic/narrative domain over time. In more than one clinical example, this was implied. The subject whose history involved parental neglect had a more difficult time engaging in the referential process and moving from the subsymbolic to symbolic representation. Types of trauma and the amount of damage incurred may affect the ability to turn somatic data into metaphor/imagery/narrative.

As there is evidence that the therapeutic relationship creates a somatic representation that could replace fears and anxieties associated with old attachment patterns (Schore, 1996), intervening at the level of the body may be exactly what some patients need. It may also be evidence that a capacity has been damaged, and accommodation has been in the direction of a highly developed capacity to use somatic information as cue and a limitation to the depth of healing that can occur (for both parties).

As most therapists in the study did not seem to deeply ascribe to the concept of projective identification, data could change based on therapists who did. However, if super-ego criticism was indeed the factor impairing the observational capacity of sensation or reaction, it seems therapists who volunteered to speak about these things may be less hindered in this aspect.

It may have been useful to also speak to therapists who had somatic sensation in their clinical work, but did not identify as someone who had experienced trauma. It may be interesting to discover whether super-ego judgments may be less in terms of "if it's mine, it is critical I not work through it in their session."

Participants used their internal objects, or in Bollas's (1992) term, *spirits*. And while the metaphor/sensation/imagery did not capture the "who" of what spirit inhabited whom, they were clearly powerful. Participants had to slow their breathing so as not to feel suffocated, get patients

to do jumping jacks to keep from "bleeding," and call upon identities to not sink into surrender. It isn't so "odd" that a participant could not tell if she were afraid or aroused in a session, if we could understand the spirit who made it so. And, therapists made use of them. And when I, the researcher and, thus, witness character in *A Descent into the Maelstrom* asked for theory and words and conceptualization, I sometimes felt that I was being looked at as quite naive. The survivor knew that he could never really explain to the witness what he had seen. Perhaps survivors, having mad and drowned and maelstrom spirits at their assistance, understand that words may not always be where the action is at. Indeed, the maelstrom survivor had to take the witness back to the cliff to try and *show* him something of the experience. He felt grief that he would never be able to thoroughly communicate what he had been through. Participants *showed* me what they could not communicate by invoking a dissociative state in me, a confused/grateful/irritated state, and a state of awe and respect.

Morton (1997) writes that psychic "Ghosts can be laid to rest through a process of separation, re-integration and re-attribution, a process which reflects a move from the paranoid-schizoid position to the depressive position" (p. 1). Surviving therapists may be actively involved in this process in working with trauma patients. There is potential for this dynamic to harm the patient, as they may be unconsciously used for the therapist's own benefit. There is also possibility for mutual growth.

Regulation style may interact with spirits in the sense that therapists may engage again and again with their own victim self-state in the patient. Comforting them (or forcing comfort on them) or rousing them from dissociative deadness could all be ways of restoring the surviving therapist's sense that they are saving their victim self.

Harris (2006) notes that therapist rescue fantasies relate to precocious childhood

caretaking and asks if analysts may "rescue only to disrupt our own and our patient's mourning?" (p. 4). Aggression/protection metaphors linked to Harris's sense that "a place for aggression and apparent ruthlessness seems to me the antidote of heroic rescue, in that self-care intertwines with care of another" (p. 8). Mourning (and self-care) requires a tolerance of one's own drowned brother. Bringing another from a deadened space, over and over, may be an enactment that reflects the wish of what could be undone rather than the sorrow over what has been done and what can never be.

Fleiss (1942) noted that super-ego criticism can impair the therapist's ability to reinstate separateness and observational capacity during projective identification. For participants, some super-ego activity seemed to be tied to their idea of the ideal therapist (non-aggressive, masochistic) and their own victim identity. Fairbairn (1943/1986) defined the "moral defense" as children taking in the badness of their parents to protect the sense that those they depend on are good. The objects that they internalize are "unconditionally bad: for they are simply persecutors" (p. 109). In "so far as the child is identified with such internal persecutors, or (since infantile relations are based on identification) in so far as his ego has a relationship with them, he too is unconditionally bad" (p. 113). Protecting inner badness (and thus outer safety) can be seen in the attempts to regulate the "good" patient and not the self, in acts of "enduring" in therapy, in feeling critical of reactivity in session and in feeling guilty over aggression. Unconscious bad objects are "likely to be activated by any situation in outer reality conforming to a pattern which renders it emotionally significant in the light of the unconscious situation" (p. 120). Surviving the patient's attacks, transference, and trauma-associated spirits are all likely to invoke repressed bad objects-and masochistic responses in therapists. Indeed, therapists must be able to tolerate the patient's transference (without retaliation or ejection) to foster the release and healing of the

patient's bad objects. A therapist's shame may also be activated when they stumble upon mutual wounds.

Sometimes it seemed as though participants were operating in subsymbolic territories that were also difficult to verbalize. It is an arena that "can only be mapped partially in words" (Bucci, 2011, p. 49). Subsymbolic processing "may operate within awareness, but we may not be able to capture it" as processes are hard to systemize and represent. It may be that this type of knowing proves difficult for people to language, which would likely be different than the difficulties in symbolization associated with trauma. Participants echoed Bucci's sense that applying "general mappings that have been used in other domains" to subsymbolic processes can lead to blockage and therapists losing their way in the work (p. 49).

Participants had made a decision to speak with me about their somatic experiences and trauma. Although they volunteered for the study, there was some indication that there were some feelings of nervousness, ambivalence, or dissociation in discussing their journeys into and out of their own and patient's maelstroms. One participant gave me the wrong address to her home, where we were to meet for the interview, suggesting some unconscious ambivalence and/or dissociation. It was, indeed, the interview that seemed to begin in a dissociated place. Regulation strategies were clear at the onset of interviews as I watched how participants used strategies to prepare themselves for the interview. Tea making and offering, lotion being smoothed onto the skin, and asking me questions all showed an effort to ease into a comfortable place in which to view the maelstrom. They carefully walked me to the edge of the cliff where I could get a glimpse of the maelstrom, although we both understood it was only a glimpse.

Despite ambivalence, nervousness, or dissociation, participants spoke meaningfully about their experiences. They were curious within the interview and made new observations about their

experiences as they spoke. Participants, despite feelings of discomfort, had clearly maintained an interest in what their bodies were saying to them and how their trauma did or did not impact their work. They acknowledged feelings of helplessness and fear but kept returning to the maelstrom to peer into its depths and to sometimes jump into them with patients (and with the interviewer/witness). In this was a distinct quality of strength and sensitivity.

Just as participants had asked themselves "is this mine or theirs?" it seemed impossible for me to sort out the origin of some of my sensations. In the interview that I felt "out of it," it was unclear to me whether I was the one who had begun the interview that way. I hadn't felt that way with other participants but could not pinpoint what had gotten me into the dazed, far-off state. It was not uncomfortable; rather, I had wished I could have closed my eyes and listened. It was not the curious wonder of the survivor who peers into the maelstrom; it was a dreamlike desire to be half-asleep. I wondered as the participant spoke about patients who were not "really there" and her use of aggression to awaken them into themselves. This may be evidence that projection and projective-identification can be active in the therapist as well as the patient. Perhaps in this version of the maelstrom, the surviving therapist continues to make the journey back to the maelstrom to pull his drowned brother up. Even in a merger, it is different spirits that are invoked in each party. In a merger, the self/other distinction blurs and temporarily it carries aspects of both, and this is what creates the fertile "muck."

Implications

Participants explained that early in their career, containing difficult affect or sensation was overwhelming and unexpected. It is likely that experiencing the same spirit or emotional schema over and over created a type of familiarity that allowed for containment. With familiarity

came names and metaphors, images and associations, and memory. The referential process was occurring.

Participants could name few supervisors that seemed interested in their somatic reactions. They explained that the body was not talked about in their training and supervision and they rarely heard about therapist personal trauma. They had stumbled upon their reactions and eventually found places to speak about them. The therapist will have a difficult time of containing their affect if they feel it is not a part of their identity as a therapist. Super-ego judgments can limit the therapist's journey to the maelstrom and keep them from maintaining a willingness to make sense of unknown and painful experience. Therapists with

> histories of trauma or loss can feel profoundly shameful. But our fears of being seen as flawed or scarred or still struggling with some aspect of our lives only make us less useful to our patients. Our need to be beyond shame makes us hide from our patients. Ironically, it is in the recognition that we all have areas of shame that the shame itself diminishes. It is our responsibility as analysts to allow ourselves to be vulnerable and to risk our own shame and fragility. Not to do so is to abandon and demean our patients, to sit and look at 'them' from afar rather than to join with them on a scary but ultimately hopeful journey. (Silverman, 2006, p. 527)

Training programs can ease shame by treating the student's somatic and countertransference reactions as useful and relevant data. Being fully in one's experience and having the ability to reflect on it implies that a certain degree of healing has taken place and actively traumatized therapists will not have this capacity (Silverman, 2006). However, the concept of the fully healed therapist is a fantasy and case conferences can facilitate the normalization of therapist unhealed wounds, decreasing shame and making room for exploration,

accommodation, and use of the unhealed places in the therapist. The expectation that these places will be touched upon in the work should be assumed and programs can make space for discussions that bring to light the reality of doing clinical work.

Tolerating intense emotional states can be seen as a part of the job. Helplessness as *doing one's job* moves toward a new experience of helplessness and may reduce the desire to eject the experience through passive-to-active action on the part of the therapist. Identities that incorporate aggression may allow for *thinking about and experiencing* aggression versus retaliation for patient attacks. The surviving therapist must tolerate and contain the self-states that appear but their therapist-self must survive.

Feelings such as *this is mine, it is critical I not deal with it here* may be containing (in that it is orienting towards a non-victim state), but it may also leave the patient behind. Cavalli (2011) writes that once both analyst and patient mind are tuned in to each other, the "analyst makes use of his mind to think what is unthinkable for the patient" (p. 1). Some participants struggled to do so, perhaps because what was unthinkable for the patient was also unthinkable for the therapist. These may be the places where the therapist leaves the patient behind ("this is mine, not theirs") or when some sort of action occurred in the therapist. Participants realized connections between their patient's experience and their own countertransference in the interview; suggesting that some degree of understanding may be more attainable outside of the therapy session, in consultation, supervision, or in moments of reflection.

Supervisors can be interested in somatic experience and subsymbolic territories. They can engage in tolerating the supervisee's activated core, inviting discussion of somatic reaction or associative material that develops, using the associative material in understanding the patient. The referential process can be experienced in case conferences and supervision: but containment

has to be fostered...room must be made. Students thus develop an understanding of how to work with whatever damage has been incurred by trauma and with whatever spirits make their presence known. By attending to reactions as important and necessary data, familiarity can lead to the use of reactions as cues. For some (perhaps who have histories of early neglect), this may be an accommodation to being unable to proceed to narrative levels of understanding. These therapists may need help in noticing their sensations and engaging in self-care so that they will not reach a traumatized level of anxiety and helplessness.

All participants had come to understand that they needed certain things to be in place for containment to occur. Interestingly, one woman did not need to go to the bathroom during sessions once she had given herself permission to do so. Surviving therapists may struggle in differentiating self-care and containment from self-sabotage and masochism. They may need models early in training to understand self-holding and surviving. One participant recalled supervisors not understanding or becoming critical of her need to self-soothe in session. Here, the participant had come to terms with the ways that unhealed trauma may limit her ability to bear certain experiences. She has accommodated through knowing and accepting these unhealed parts of herself and tending to them so as not to experience the traumatic process (i.e., helplessness, surrender) in session. Supervisors and consultants may also need to come to terms with such damage in the supervisee and support certain accommodations.

However, much of what was discussed in terms of bad objects and the moral defense are related to psychic structure. While it is likely that therapists are often unknowingly healing aspects of themselves in their clinical work, personal therapy may reduce the likelihood that such a gift is not at the expense of the patient. Training programs can require personal psychotherapy for laying down ghosts and making room for spirits.

While different people have different capacities for recognizing data within themselves, capacities can be nurtured. The internal world can become marginalized in training. There is much to pass on and education is susceptible to the same socio-economic forces that the field of psychology is. And yet, without room for discovery and interest in subsymbolic and sensory data, in the therapist as a person, and in the intersubjective world, some therapists may never familiarize themselves with their spirits; rather, they will only be haunted by them. It is difficult to teach the practice of therapy precisely because it is a process like many other forms of art. Experiences in clinical work, supervision, and personal therapy can provide journeys (in and out of the maelstrom) that can instill the sense that it is "worth it"—both for the patient and for the therapist.

Surviving therapists can be nurtured through incorporating into their "job description" attunement to subjective experience, self-care/containment, and subsymbolic data. Acknowledging the benefits one gains from providing therapy may ease super-ego judgments that may leave the patient behind ("this is mine, not theirs") and fail to honor the intersubjective area of therapy. In doing so, feelings of helplessness can be contained with the sense that one is planted in their role, even when venturing toward the edge of chaos. Wounds that cannot heal can be accommodated to, but this may require a painful acknowledgement of the damage one has incurred from personal trauma.

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Appendix A: Participant Informed Consent

I understand that Rachel Urbano, a doctoral candidate at Antioch University New England, is requesting my participation in a study for her doctoral research. The purpose of this study is to document the experience of survivor therapists' experiences of working with trauma survivors, particularly in the area of somatic countertransference. I wish to participate in this study so that others may benefit from the documentation of the survivor therapist/patient match, particularly the ways in which somatic countertransference is experienced and utilized.

I understand that participation in this study involves:

An in-person interview approximating one-hour in duration
An optional follow-up call for referral services

I understand that the interview will be audio-recorded and, thus, give my consent to be recorded.

I understand that the following actions will be performed to maintain confidentiality:

All data will be locked in a file maintained by the researcher who will have sole access to the files.

When published, all identifying information will be removed and managed in such a way that identities are unable to be discovered. As part of confidentiality, participants will be informed that the researcher is lawfully required to report to authorities any reasonable suspicion of child, elder, or dependant abuse or injury of a participant (Mertens, p. 334).

Audio files will not carry identifiable names of participants.

When research is completed, all confidential materials will be destroyed.

I understand that confidentiality may be broken if I disclose current abuse of a minor or vulnerable adult or if I am a danger to myself or others.

I understand that Rachel Urbano will review the tapes, and that portions of unidentified material may be shared with a peer reviewer. The information gathered from this study will be used solely for the purposes of this study and any later publications from this study.

Potential benefits of participation include possible self-discovery, participating in creating an opening in the literature for surviving therapists to document and benefit from each other's experiences and expertise, and reducing any stigma that may be associated with the limited discourse in the literature around the surviving therapist experience.

I have been advised that this study carries a high potential for triggering of traumatic memories and associated physical sensations, feelings, and images. I agree to contact the researcher if, following the interview, I need assistance in finding a referral to process my experience.

I understand that participation in this study is completely voluntary and that I may discontinue at any time with no penalty. If I wish to withdraw from this study, I understand that all I will need to do is contact Rachel Urbano at 413-588-8818. I also understand that I have the right to refuse any questions I do not want to answer. All data will be erased at the time of my withdrawal from the study. If I have any concerns regarding breach of confidentiality, ethics, or any other matter that I feel uncomfortable contacting the primary researcher, I agree to contact the chair of the study, Victor Pantesco, Ed.D at vpantesco@antioch.edu

I have had this document explained to me and understand its contents. I have a copy of this document.

Date _____

Signature of Participant _____

Appendix B: Semi-Structured Interview Protocol

1. Can you please describe the nature and extent of your work with trauma patients?
2. How and why did you decide to participate in this study?
3. What differences do you experience in your work with trauma patients/vs. not traumatized patients?
4. Can you discuss somatic experiences you have had with trauma patients?
5. Are there ways you have used somatic countertransference to understand something about the client? What did it inform you about the treatment, the relationship, or the clinical moment?
6. How did you learn how to work with somatic countertransference?
7. Can you speak to experiences you may have had where you felt somatic countertransference in session was not useful in your understanding of the client and therapy? How did you make that distinction?
8. Have you disclosed somatic countertransference? Was this useful? How so?
9. Do you have similar somatic experiences, or do they differ (different sensations with different patients?) What do you make of this?
10. Do you find you have somatic experiences more frequently with trauma patients?
11. Have you had supervisory/consultation experiences that helped you to utilize somatic experiences?
12. What has it been like discussing these things with me today? Have you noticed sensation in your body come up in the re-telling of events?

Appendix C: Participant Recruitment

Are you a therapist who works with trauma?

I am a graduate student at Antioch University New England completing my doctorate in clinical psychology and working on my dissertation titled "Body of knowledge: Somatic experience and trauma."

PURPOSE
The purpose of this study is to listen to the ways therapists have recognized, experienced, understood, and utilized physical sensations they have had in the context of trauma treatment. In the effort to understand this process, my hope is to illustrate the ways in which therapists may utilize their bodily experiences to inform their work with trauma patients.

METHOD
You will be interviewed for about one hour. If you are comfortable, the interview will be audio recorded to aid in data collection. It is my aim to have a conversation about the times you have had physical sensations in the context of trauma work and how you came to understand these sensations. It is my hope that the flexibility of the interview will allow you to direct the conversation to areas you feel most relevant to your experience.

PARTICIPANTS
Participants should be licensed social workers, psychologists, analysts, or therapists. They will be unnamed in the study unless they request otherwise. They should fall into one or more of the following categories:

- Therapists who have had a physical sensation that occurred within the context of trauma work.
- Supervisors who have encountered the phenomenon indirectly through supervision activities
- Therapists who have experienced the phenomenon and have trauma in their own backgrounds
- Experts in the trauma field who have some understanding of the phenomenon based on professional activities

COMPENSATION
Participation in this study will not be compensated.

MORE INFORMATION
Please contact me if you would like to participate in this study or if you would like to ask me questions. I can be reached at Rachel_urbano@antiochne.edu or 413-588-8818. I am happy to discuss the study in further detail, determine if you are qualified to participate, and send you the informed consent forms. I look forward to hearing from you.

Sincerely,

Rachel Urbano, M.S.