A DEVELOPMENTAL APPROACH TO WORKING WITH EMOTIONAL TRAUMA AND DEFICITS IN ADULTS

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Q Has anyone ever said to themselves "I don't feel like myself today". OR I just can't get myself together today OR Something like that?

Q Have you ever wondered why you feel like that?

Let's take a look for a minute at the childhood story of Alice in Wonderland and see what she says

. Alice's Adventures in Wonderland.

> `Who are YOU?' said the Caterpillar. Alice replied…I hardly know, sir, just at present-- at least I know who I WAS when I got up this morning…, but I think I must have been changed several times since then.'
> `What do you mean said the Caterpillar explain yourself!' `I can't explain MYSELF, I'm afraid, sir' said Alice, `because I'm not myself, you see.'

This is a beautiful metaphore of our struggles with identity that affect all of us at some time in our development. But I'm not sure if we are always so clear or aware of the duplex nature of 'self'. So let's go on to see what Alice says about that.

> "Alice goes on… `Come, there's no use in crying like that!' … sometimes she scolded herself so severely as to bring tears into her eyes; and once she remembered trying to box her own ears for having cheated herself…she was playing against herself, for this curious child was very fond of pretending to be two people."

The writer suggests that Alice was pretending to be two people, but was she? One part of Alice was beating up on the other part of herself that she was frustrated with. One part, frustrated and critical. The other part hurt, unhappy and ending up crying.

Why does there appear to be a contradiction with how she is feeling and her responses to those feelings. Why was she not kind to herself. One part of herself is angry with the other part of herself. The other part of herself obviously didn't want her to be angry with herself because it made her cry. Complex - yes

Is there a contradiction here or is there some other way of explaining this? Could it be possible that these are two identifiable states of being within the one person.

We are not talking here about DID or schizophrenia or split personality. This is more about a part of us that has become stuck or developmentally delayed because of early trauma while the other part of us has had to grow up.

*(5)***Van der Kolk and Van der Hart say that "…trauma stops the chronological clock and fixes the moment permanently in memory and imagination immune to the vicissitudes of time...the traumatised, fixated, inflexible part of the personality has stopped developing." (p.176-7**

These unconscious traumatic memories come to control behaviour and …the trauma is relived repeatedly, until the person learns to remember simultaneously the affect and

cognition associated with the trauma through access to language (Vander Kolk and Ducey)

These people "…experience long periods of time in which they live, as it were, in two different worlds: the realm of the trauma and the realm of their current, ordinary life…"

We can see from this that trauma in infancy

- causes development to stop,
- fixes those traumatic memories in the unconscious where they are stored and
- creates two different worlds that the person lives in.

Since we are talking about a disruption in development we need to go right back to the beginning and take a look at what is being said in recent times about development and the brain.

Recent brain research indicates that when babies are born they don't have any of the neuron's in their brain connected. These neuron's grow as a result of early interactions with others either nurturing or traumatic.

Daniel Siegel's book "The Developing Mind – How Relationships and the Brain Interact to Shape who we are, says:

"**Human connections shape the neural connections from which the mind emerges… Current neuroscience provides us with new insights into how experience shapes mental processes."** And he goes on to say that

"In a direct way, experience shapes the structure of the brain…experience directly shapes the circuits responsible for such processes as memory, emotion, and self-awareness…past events can directly shape how and what we learn, even though we may have no conscious recollection of those events…Our earliest experiences shape our ways…of relating to others, without our ability to recall consciously when these first learning experiences occurred. (p2,24)

Interpersonal experience thus plays a special…role in determining the development of brain structure early in life and the ongoing emergence of brain function throughout the lifespan." (p24)

Early experiences are stored in the unconscious as traumatic or nurturing memories. They are relived when something similar is experienced in the present and triggers the unconscious memory into action. (within 1,000th of a second). It takes the conscious memory 5 whole seconds to try and work out what just happened.

John Bowlby talks about the importance of secure attachment on the developing brain. He says that if a child doesn't attach to the mother in the first 24 hours of life then the child will rapidly become anxious. It's an early experience of separation long before the baby has had the chance to experience the security of safe attachment. So the separation causes fear of abandonment that results in the feeling of anxiety.

Allan Schore quotes Bowlby in talking about the importance of attachment on the developing infants right brain which he says develops before the left brain.

"Attachment experiences of the first 2 years thus directly influence the experience-dependent maturation of the right brain. These include experiences with a traumatizing caregiver, which are well known to negatively impact the child's attachment security, stress coping strategies, and sense of self"

The early forming right hemisphere stores an internal working model of the attachment relationship… [and] is encoded in implicit memory, which is primarily regulatory,

automatised, unconscious. This right frontal system thus plays a unique role in the adjustment or correction of emotional responses…and regulates the duration, frequency, and intensity of not only positive but also negative affect states.

If the early problem with attachment is an isolated experience and other interactions encourage feelings of safe attachment then no harm is done.

However, if the child continues to have minor separations such as being left ot cry themselves to sleep, then a traumatic memory pattern develops.

In spite of what we may think one catastrophic event doesn't create a traumatic memory it is the repetitive nature of something that makes it traumatic. It is the many repeats that allow the neurons to grow. Anyone who has or has had small children knows how many times you have to repeat something for the child to get it. The same happens with traumatic memories. If it is repeated the child eventually 'gets it' that is the neural pathways have connected and the pattern is set

BUT DON'T PANIC

The important thing to remember here is that the brain is plastic, as highlighted by Richard Hill in his talk on "What has the brain got to do with it" at the PACFA/ACA Conference in October last year.

What he said is that it is possible for the brain to change and grow new pathways. But this means that there needs to be as many positive things repeated in order for the brain to grow the new capacity. As I was told early in my psychotherapy supervision, a 1,000 repeats to fire off in the forebrain.

Recent TV Show about a child who had been raised with dogs in a dog kennel. She could only bark. She was taken from the kennel at about 11 or 13 and taught to speak. When she had achieved this, the teachers left her but she couldn't sustain the learning so she just went back to barking. She had the capacity for speech but unless there had been sustained repetition of these sounds then the brain didn't grow the neurons to sustain speech and she lost it.

The same happens in the emotional realm when we are helping people who have been traumatized. Unless there are repeated responses over a period of time they cannot sustain the new emotional experience as the brain cannot make the connection.

HOW DO WE MOVE FORWARD

We grow up and function in the world as workers, partners, parents etc but our emotional responses can often indicate that we are developmentally stuck at an early age, the age when the trauma started. That is we repeat those early traumatic responses as the brain hasn't received what it needs for us to move on from there.

Therapy is about giving words to those early pre-verbal experiences so that the person can get what they need, that is, be responded to in a positive healing way that allows the brain to grow new self nurturing, positive pathways.

The important thing is to work out how do we turn this knowledge into a way of helping people to grow up the emotional part of themselves.

If we let people believe that they (the whole of them) is damaged and needs to grow up then it is quite devastating.

We have to help them connect to the part of them that is grown up and functioning while we look at the part that isn't functioning and hold these two in tension while we do the work together.

Underpinning this process, although not explicitly discussed here, is the awareness of the importance of the provision of **Winnicott's 'good enough' mothering/parenting** that encourages a **safe empathic attachment in the therapeutic relationship.**

TWO INTERNAL STATES OF BEING.

In referring to these two states we think of them as

Feelings vs Cognitive states
Traumatised vs Non-traumatised states
Coping vs non-coping states

But from my experience they are not really helpful with clients so I prefer to refer to them in client friendly terms such as 'adult state' and 'child like state', or 'adult and little part or person', or derivatives of these because they embody personhood.

The concept is that we are people with a real life history. We have been a little person disrupted in our emotional development and now are adults who have to live with the disrupted state or states and work out how to manage our life.

I will be using two cases to refer to.

Beth, a Borderline who I have been seeing for 10 years, and
Sarah with OCD, who attended with me for 6 years. (not their real names).

I talked to Beth about this paper and asked her what words she would have preferred I had used, during her therapy when referring to these two states. This was her response.

"Little girl and adult… because I know there is a little person that couldn't grow up because she wasn't cared for. I picture her with curly hair and I'm holding her hand – I understand it more". Those other words don't make sense to me, not a real space."

Beth, a nurse, used the example of patients who break their arm and call their plaster by a name. She said "they have an identity for this plaster so it's much easier for them to accept it".

It needs to be said at this point that I am not talking about **inner child work** where the focus is on a traumatic event and encouraging people to re-parent themselves. Rather I am focusing on the early developmental disruptions as the source of trauma and the therapeutic relationship as the basis for healing.

Why use these terms ?

My clients have shown they can relate to the terms adult and child because they embody personhood and gives these two states identity. It also helps to deal with the confusion around contradictions and calms the fears around the loss of self when in a fragmented state.

Some clients struggle with this concept at first. But I haven't had a man or a women who hasn't embraced it in the end. For many, it raises the issue of shame around being perceived as a child. Helping them see there is an adult part of them that is fully functioning in the world, competent and capable allows them to feel they are not wholly this child and therefore not completely lost in the trauma.

They then know that the trauma is not all of who they are. "I'm still OK even if the child in me is struggling". They are more ready to take ownership of this traumatised part of themselves and work towards growing up

With clients, who struggle, I simply talk about the contradictions and get them thinking about that first. When they are comfortable with the two spaces inside themselves I may suggest this

concept that others have found helpful, or wonder with them what it might mean if one part was the child that couldn't grow up because of the trauma and the other part was the adult.

Some clients want to 'kill off' this part of themselves because it causes them so much pain. Even when they accept that it is a 'child-like part', they sometimes still want to because the pain is unbearable.

However, when they can understand that they need to embrace the child in them in order to move on, and that the child has been stuck in this pain and needs to be cared for in order to get well, it helps to shift the desire to 'beat up' on themselves just as Alice was doing in the children's story.

It slowly dawns on them that if they keep beating up on the child, they are being just like all the others who did the same, and if they keep doing the same there is no chance of getting better.

Acceptance of these two states

With the acceptance of these two states, what was once perceived as a contradiction, conflict or paradox is now easier to understand.

The two different feelings or ideas are not in fact contradictions, conflicts or paradoxes but two different developmental stages. One part has grown up but the other part hasn't and is stuck in the trauma.

Our job is to work together to get unstuck and complete the developmental process. Clients can then accept not only that part of them that needs to be cared for in order to 'grow up', but also their role in helping it happen.

I watched a recent program on TV about the Salvation Army's work with street kids. They interviewed many, but one in particular touched me. She had a good understanding of the voices in her head and it was very clear that she had owned them, yet she talked about all the strategies she had for making them go away. She believed the voices were ruling her life (and she was right) and she would be a lot better off if she got rid of them. I felt somewhat frustrated and sad that there was so little understanding that this meant killing off the little girl in her who had been talking a lot in her head, but had never really been heard or understood.

Contradictions/Paradoxes in Therapy

When contradictions or paradoxes appear in therapy, conceptualizing them as **two different developmental stages** can help clients deal with the early developmental concrete thinking that things are either black or white, or right or wrong. Often this struggle with accepting the two different ways of feeling or thinking ends up with **splitting off one part, in order for the other part to exist.** Clients rationalize they can't have two different feelings, one must be wrong, they feel they have to get rid of one of them.

My response to them is "the child in you feels that way and you feel another way. They are both there and they are both true. It's not one or the other but both. Or **"that's how the adult you feels, but I wonder how the child in you feels about that?"** This allows the child to have a voice.

The reverse is also true where the child is the only one with a voice. **That's how the little part of you feels but, I wonder how you [the adult] feels about that**. However, I only offer these responses when I am aware the client has some reflective capacity, has accepted the concept and is comfortable with it.

Schore supports this when he says that "…a mature brain that…is capable of exhibiting adult response patterns… may regress to an infantile state when it is confronted with severe stress."

Waiting for change

The difficulty is always in holding these two in tension until the child is able to grow up. It causes clients much frustration. Schore talks about the development of the right brain being dependent on the early attachment relationship and in answer to clients fears and frustrations about "When this is going to change". My answer is when we have been together long enough for your brain to complete the task of developing new pathways. Then you will be able to hold onto the good stuff and do the things you want to do, and you will know that you have changed.

This seems to calm the fears that it will never happen and makes the waiting easier at least for that moment anyway. To me this mirrors the developmental stage of early childhood where it is necessary to give a young child some basic facts in order to soothe a fear.

Alan Schore says that "severe trauma of interpersonal origin may override any genetic, constitutional, social or psychological resilience factor, and that the ensuing adverse effects on brain development and alterations of the biological stress systems may be regarded as 'environmentally induced complex developmental disorder'."

STAGES OF DEVELOPMENT

I am assuming that everyone has a knowledge of the developmental stages over the life span. For the purposes of this paper we will only be considering the early stages, since this is where trauma has its greatest impact on the development of a sense of self. Trauma experienced at later stages of development, merely builds upon the earlier traumatised self system. These later stages always remain incomplete until the early stages have been reworked.

Early Childhood Development

Infancy Tasks (0-18mths)		**Traumatic Consequences**
Attachment/security/ Intimacy	vs	**alienation/insecurity/aloneness** (*abuse and neglect*) **anxiety/fear** (*abuse and perceived or real loss of significant other*) **shame/frustration** (*parental misattunement – needs not OK*)

Toddlerhood Tasks (18mths – 3 yrs)		**Traumatic Consequences**
Trust/autonomy/ Separation	vs	**mistrust** (*abuse and neglect – relationships not safe* **shame/doubt/fear** (*overprotection, misattunement, parents are right I am wrong, fear trying new things)* **frustration/compliance** (*Parental control – separation and own ideas or ways of doing things not OK*)

Early Childhood Tasks (3-6yrs)		**Traumatic Consequences**
Initiative/curiosity/risk taking Creative experimentation	vs	**guilt** (*child perceived to be disobedient, intrusive, disrespectful or rude by caregivers*) **Fear** *(fear of punishment and not getting it right)* **Shame** *(from actual shaming by caregivers & others)* **Frustration** (*over feelings of powerlessness when frustration is not understood*) **Anger/Rage** (when *frustration is repeatedly not understood*)
Identification - observation/ Imitation/modeling/adopting (*of beliefs, attitudes,& values*	vs	**Compliance/rebellion** (*against identity confusion*) **Fear** (*can be from real objects they now recognize – I don't know what I should be afraid of - but escalates/piggybacks on earlier fears)* **Shame** (*at not measuring up to parents perceived or real expectations ie not being acceptable to self or others)*

I know you will be aware that the process of identifying and working with developmental deficits and trauma is not linear and therefore I won't be addressing this in a linear way.

DEVELOPMENTAL ARREST

Time moves on but it doesn't change anything for these people. Except for therapeutic intervention, they remain fixed in the early emotional space. I wonder if sometimes it doesn't feel like ground hog day to them.

As Beth would often say, this is always happening to me, I keep doing the same things, I hate it. Why do I keep doing that? The inflexibility that is part of immaturity was very frustrating for her as for all clients in this space.

Sarah's frustration was even more evident in the chronic ambivalence she experienced. For all of her 20 years of married life she struggled with doing the dishes. She hated doing them and hated even more doing them alone.

No one in the family could do the dishes 'right' so everyone had given up helping and Sarah was left to do them alone, which she hated. The pattern almost never changed. Ground hog day couldn't have been worse for her than this.

It took 5 years of therapy for her to make the connection that her little girl was locked into having them done right because her mother punished her if things didn't meet her standards.

CASE PRESENTATIONS IN THERAPY

Sarah and Beth both presented at a very early stage in their development. Even though the feelings of early infancy, such as shame and fear, were there for both of them, they presented quite differently.

Schore talks about the two separate response patterns to trauma. Hyper-arousal and dissociation. In the early stages of therapy Beth was always in a hyper-aroused state and Sarah in a disconnected dissociated state.

BETH was chronically agitated and sobbing in her therapy sessions. Her need of me was intense both in therapy and between therapy. It was constant and demanding like we would expect with an infant but it was difficult for her to allow herself to be soothed because of the shame. This shame was evident during the sessions in her attempts to hide from me by looking away. Her needs were shameful, she was despicable and stupid and she sobbed uncontrollably.

If she looked at me there was a huge fear that my facial expression might not be accepting and might traumatize her. Looking at me might prove that her need was unacceptable and she was despicable. I had to remain vigilant in ensuring that my facial expression portrayed a calm acceptance so this wouldn't happen. If I was distracted I would always tell her so that she would know that it wasn't her.

This went on for 4 years of therapy. I had to learn to be creative in order to encourage the kind of empathic connection that would allow her to develop a mature sense of self.

One creative moment came when Beth gave me a bunch of daffodils. I was again sitting with her inconsolable sobbing when I remembered a poem in Winnie-the-Pooh. I got my book and I read the poem to her.

DAFFODOWNDILLY

She wore her yellow sun-bonnet,
She wore her greenest gown;
She turned to the south wind
And curtsied up and down.
She turned to the sunlight
And shook her yellow head,
And whispered to her neighbour;
"Winter is dead"

She stopped crying and looked up with wide eyes. Spurred on by this, I read more and as I did, she allowed herself to be comforted. I was also aware that it was not only the reading but my tone of voice that was important in moving her towards internal affect regulation. It is the soothing & calming provided by the mother that regulates the child's affects, as Bowlby says "the mother shapes the development of the infant's coping responses".

Next session she came back and said, "*no-one has ever read to me before*". I gave her the set of books and she returned the following week to tell me that she had read them to herself and it helped to drown out the trauma happening around her. It was a significant step forward that on reflection couldn't have happened if I wasn't able to listen to my gut and go with it.

SARAH on the other hand was disconnected from herself, her experiences and from me in the therapy. **Van der Kolk and Van der Hart say "…when dissociation has been learned as a coping strategy it is continued to be used in response to the slightest stress and unconscious memories come to control behaviour"**. Like Beth, Sarah could not look at me and even though her need of me was the same she had no connection to this, she just talked to

herself in a detached reverie. Occasionally she would connect sessions and remember what I said but otherwise therapy sessions remained disconnected segments in her chaotic life.

Developmentally Oriented Therapeutic Responses

Working Developmentally means working at the same level as the feelings, behaviours, and attitudes that are being expressed in the moment. Our response will be different according to the presenting developmental stage and will ebb and flow with the progress of therapy. I have chosen just two affects, fear and shame, to reflect on here, as they both occur at each stage of development.

1. FEAR

Clients presenting fear will be different to fears expressed at later stages of therapy. The fear categories I have used here are taken from the classic childhood text "Things that Go Bump in the Night**"**

The Fear of the Infant - is a fear of abandonment or annihilation

With **Beth** this was the same fear through all the early years of her therapy. The fear would paralyse her. In this regressed space she had difficulty finding words and forming sentences. She simply made noises similar to those of a baby. She needed to be held emotionally, and constantly reminded that I wasn't going to leave her, or abandon her, that I would be there for her, and I would see her through this.

Sarah had no sense of relationship. She said she didn't know what relationship was. To attach to people was not safe so her fear of abandonment was taken care of by her routines and the things she collected. The paradox for Sarah was the knowledge that love was not in things but felt it must be if she held onto them. She was afraid if she let go of them she would feel abandoned. Sarah needed me to reflect this dilemma and let her know that I cared about her and wanted to see her through this.

The Fear of The Toddler - The fear of the power of big people. (Parents and authority figures).

Beth presented in therapy in 2000 with a desire to leave home, however her mother and step father threatened her with being 'cut off' from the family if she did. She was unable to make the move because of the fear of the consequences yet she couldn't stay home because contact with both parents caused severe fragmentation, they had the emotional power. My response was to empathise with her struggle and how hard it was to do what she wanted and wait until she was emotionally strong enough to make the move, which she eventually did.

Sarah's fear of big people was expressed quite differently. She needed the help of others but was afraid they would take over. She didn't know what I thought about her but was afraid to find out. She said "*it's easier not to think about it*". She could describe to me how I might see her mother as "*a tyrant to pathetic and sad*" but was unaware of her fear that I might see her the same way. She could never ask. Sarah needed to build her trust in me that I could be there for her. I needed to actively respond without telling her what to do or taking over, and not judging her. She needed my unconditional acceptance.

The Fears of Early Childhood - I'm afraid I might not get it exactly right. Can I take that risk.

Beth had progressed in therapy and was able to start a course of study. During this time she would regularly come with fear that she couldn't pass the tests and that she was going to fail. She needed me to constantly reassure her that she could do it. That I believed in her, that I knew she was going to get through it. It was very important that I didn't collude with her fear at this point. She needed me to believe in her ability. She did pass and did very well.

Sarah's fear was wanting to take a risk but needing to do it safely. Five years into therapy she felt safe enough to ask me what I felt about her. She said what was most precious to her was someone who doesn't give up on her and in tears she said, "*You're the only one who has ever stuck it out with me*". The next session she indicated she was bewildered by this new relationship. "*I'm still looking for the way to behave here and you're not giving me any clues*". She was afraid she wouldn't get it right and it was important for me to reassure her that there was no right way. Relationships are about working it out together and we would work it out as we went along.

Fear of the Adolescent. I'm afraid of growing up.

Sarah said "*I'm so afraid of getting unstuck, of becoming unbalanced*" Fear of stepping into the unknown. The fear of the 'what if's' were huge. She feared losing everything if she stepped beyond the fear but realized she had lost everything anyway. Routine made her feel good but said routine was a substitute because it '*requires no risk'*. She said it's '*getting it from my head to my feelings, saying it's OK and feeling it and believing I'm strong enough to do it*". This was her first expression of the integration that is necessary to move through this stage of development. Her need at this point was for me to be patient with her and praise anything that even hinted at taking a risk.

Developmentaly Oriented Therapeutic Responses

2. SHAME

At a conference I attended a few years ago a psychiatrist in charge of training in the ANZAP course I did (Dr Joan Haliburn) said that we are always dealing with shame in therapy and if we accept this right from the beginning then we are less likely to trigger a traumatic shame response.

Pulver says "the feeling of shame is quite different from the fear of being shamed and is activated by the experience of the self as defective". It is only when one is held in contempt by the object that shame occurs". But a child can feel that they are held in contempt by a parent simply by being ignored.

Shame of the infant My needs are not responded to so they must be unacceptable. That makes me unacceptable and unworthy of love.

Lack of positive responses in childhood meant **Beth** could neither feel love nor accept she was loveable. Her turning away from me meant she expected I would be dismissive, angry or disinterested in her and she simply accepted it as so. The shame of being unacceptable and unworthy of love was embodied. Just as the infant expects the mother to understand what they need simply by crying, Beth needed me to understand what her uncontrollable sobbing meant and what she needed from me. Sometimes it meant simply to soothe her, sometimes to distract her and at other times to be able to reflect what I imagined she might be experiencing. (13) Bacal says "being understood…is of central importance in the curative process."

Sarah had a need to be cared for but a shame of it. 'She fantasied her need to be connected to me with phone calls in her head but she never actually called me. Just as the infant expects the mother to be attuned to their need, Sarah expected me to know when she wanted a drink of water. When I recognized the need and poured her a drink she felt special but if I did it too much she felt ashamed of her need.

[Click] **Shame of the Toddler** - I am now not only unacceptable, but I am the negative words of the other. That is, I am stupid, dumb, a failure, an idiot, rude, despicable.

As soon as either of **Beth**'s parents felt irritation it was reason enough to be cruel or dismissive. Beth believed this cruelty was her fault because she was dumb and stupid. The self loathing of her little girl consumed her and she had no ability to soothe her escalating affects. She

remained in these hyper-aroused states until something was provided that would calm her down. She needed me to be able to tolerate her intense need so that she could come to the realization that her needs were not something to be ashamed of but the consequence of her early trauma. She had no trouble connecting to the little girl in her, saying *she sometimes felt like a two year old*, but at this stage it was still not understood and a shameful thing.

Sarah's shame affected her ability to let me see her need of me, her tears or her feelings of rage. She kept a mask like face as **Hobson says "to conceal the overt expression of her shame**". The underlying question for her was always ….."what is it about me that my parents were so contemptuous of", but she can never ask.

Shame of Early Childhood - I can't get it right, can't please my parents, won't ever measure up or be acceptable.

Shame is always about acceptance and while it is easy to accept someone's pain it is not always easy to accept the childlike curiosity and intrusiveness when this arises in therapy.

When **Beth** reached this stage she got up and came over to my desk and had a look and wanted to know what things were. She needed me to be comfortable with this and answer her honestly to allow her to feel that her curiosity was acceptable.

If we struggle with feelings of intrusion they will pick up on this and be shamed whether we answer them or not. They may tell you it doesn't matter but they will turn away indicating that they feel the shame.

Sarah was ashamed of her many failures at achieving perfection. She said perfection was like trying to grab hold of a cloud or mist. With some reflective capacity she could understand that 'letting go of the rubbish in the house would leave her feeling vulnerable with nothing to hide behind'. She saw a picture of her lounge empty and felt naked. She said if all the stuff goes there would be just me and I'd have to deal with it. Sarah's fear of exposure is about shame. **Nathanson says "shame strikes deepest into the heart of man…a sickness of the soul…[she] feels…naked…lacking in dignity and worth".** Her rather delightful response to this was that she would just put a jumper on over the nakedness and keep going. And although it appears like a helpful thing to do it is still a reflection of her need to cover the shame.

INTEGRATION

Beth's little girl has grown up through therapy. She says she was never able to accept that she had issues but now is not pushing them away. She knows when she is withholding and is not ashamed to bring things forward. She can reflect on what is happening to her and is active in taking care of herself (like putting on face cream). She now recognizes that men see her as having potential and value when she used to see them as using her.

The recent loss of a relationship caused a regression to a very early stage of development but this time she had the words to describe her paranoid thoughts, rageful feelings and depersonalized state she was experiencing. "*This is not me, an evil dark person, feels like the devil in me, makes me feel scared that I'm going to stay like this. Don't feel like a person, feel like the devil controlling me, all these different masks on me. Can't accept the dark person, fear that it is who I am. If I accepted this person it would mean it is OK to be like this and going to be like the dark person forever*." She had a fear of doing something psychotic, a fear of loss of touch with reality and the evil person would take her over. Behind this was her fear that this man had left her because it was her fault and she was crazy.

In order that she didn't slip into psychosis, it was important to help her get in touch with her adult self so she could see that she was more than the child and therefore not going to be in this black place forever. I knew that she would be able to access the adult in her if prompted so I asked her what the adult in her thought about all of this. She said "*the adult knows the time we spent together was all good and lovely and fine and that he couldn't confront his mother so he*

couldn't marry me - the adult is very clever - children don't have the resources to reason this way". She then realized she wasn't going to 'be like that forever' but that the feelings had overwhelmed her little girl, just like they had done, when she was actually little.

The two states at this point were quite extreme but she was able to hold them both and not lose herself. A far cry, from the babbling of those earlier years. Her solutions to problems that arise now are, stopping and thinking and being more reflective.

CONCLUSION

So the two different states of being, are not contradictions or paradoxes if you understand them developmentally. Part is the consequence of arrested trauma and part is grown up. If clients see it as a normal consequence then they can live with it. They can then work on integrating the two states, through the process of therapy, with the awareness that these are two different stages of development.

Perhaps I have thrown down the gauntlet for some of you, to challenge the way you perceive the situations that I have described. Perhaps it has raised some questions.

References

1. Carroll Lewis, Alice's Adventures in Wonderland
2. Siegel, Daniel J., The Developing Mind: How Relationships and the Brain Interact to Shape Who We Are. 1999 The Guildford Press, NY
3. Schore Alan N., Dysregulation of the right brain: a fundamental mechanism of traumatic attachment and the psychopathogenesis of post traumatic stress disorder. [paper]
4. Gething, Hatchard & Olds, Life Span Development.
5. Van der Kolk B.A. & Van der Hart O., - The Intrusive Past: The Flexibility of Memory and the Engraving of Trauma
6. Milne A.A. Winnie the Pooh
7. Bowlby J. Attachment and Loss, 1969, Vol 1: New York: Basic Books,
8. Van der Kolk & Van der Hart
9. Warren & Minirith, Things that Go Bump in the Night.
10. Pulver, S.E., 1999, Shame and Guilt: A Synthesis, Psychoanalytic Inquiry, Vol.19, No.3. (p.389, 394,393,)
11. Bacal, H.A. 1998, Optimal Responsiveness. How Therapists Heal Their Patients, Jason Aronson Inc USA (p.11)
12. Nathanson, D.L. 1994, Shame and Pride, Affect, Sex and the Birth of the Self, W.W. Norton & Co. USA (p.146)