Building a Secure Internal Attachment: An Intra-relational Approach to Ego Strengthening and Emotional Processing with Chronically Traumatized Clients

Jerry Lamagna, LCSW
AEDP Institute Faculty
100 Chetwood Terrace
Fanwood, New Jersey, 07023
(908)-490-1449
jtandjl@comcast.net

Kari A. Gleiser, Ph.D.
AEDP Institute Senior Faculty
6 E. South Street
Hanover, NH 03755
(603)-643-0066
karig@alum.dartmouth.org

Journal of Trauma and Dissociation, (in press)

Word Count: 10, 031

KEYWORDS: Trauma; Attachment; Ego State Therapy; Experiential

Acknowledgements: The authors would like to thank Diana Fosha, Julian Ford, Barry Litt, Stephen Prior, and Jeffrey Magnavita for their guidance, insights and support in the writing of this paper.

Abstract

In this paper, we introduce *Intra-relational AEDP* (I-R) as an attachment based experiential approach to trauma treatment. Integrating Accelerated Experiential Dynamic Psychotherapy (AEDP) (Fosha, 2000a, 2000b, 2002, 2003) with ego state methodology, I-R specifically seeks to help clients by: 1) fostering capacities for self regulation through shared states of affective resonance between therapist, client and dissociated self states, 2) facilitating authentic, open internal dialogue between self states which can alter engrained patterns of intra-psychic conflict and self punishment, 3) developing abilities for self reflection and emotional processing by co-mingling previously disowned affect and emotional memories with here and now experience, and 4) attending to positive affects evoked through experiences of transformation, self-compassion, and self-affirmation. Drawing from object relations and attachment theory, I-R places particular emphasis on internal attachment relationships formed through interactions between the client's subjective selves (internal subjects) and reflective selves (internal objects). Through visual imagery, internal dialogue and explicit relational techniques, I-R aims to develop this subjective-reflective dyad's capacity for reciprocal attunement, resonance, and responsiveness, thereby fostering healing and psychological integration between the client and heretofore disavowed aspects of self.

Living a life of vitality and resilience in the face of adversity requires both access to our emotional experience and the ability to harness associated action tendencies in the service of self. Nowhere is this more salient an issue and more daunting a challenge than in clinical work with chronically traumatized and neglected individuals. The persistent remnants of maltreatment and disorganized attachment -- profound distrust, affect dysregulation, dissolution of identity, extreme dependency, and shame -- cast a large shadow over the survivor's ability to access inner resources and derive comfort from connections with others.

We believe that most psychopathology associated with complex trauma represents the survivor's best efforts at coping with recurrent, inescapable intra-familial abuse (Fosha, 2000) and developmental deficits associated with persistent neglect (Gold, 2000). A major consequence of these adaptations is the chronic segregation of affects, thoughts, actions, and perceptions -- otherwise known as dissociation -- that are deemed a threat to the integrity of the psyche or vital attachment relationships. This "dis-integration" of neural information hinders access to important emotional, somatic, behavioral and cognitive feedback about past life events – feedback that is critical to guiding future actions (Izard, Ackerman, Schoff, Fine, 2000; Ogawa, Sroufe, Weinfeld, Carlson & Egeland, 1997; Siegel, 1999).

In order to develop the survivor's capacities for psychological integration and self regulation, we have developed a set of clinical strategies built upon Accelerated Experiential Dynamic Psychotherapy (AEDP) (Fosha, 2000a, 2000b, 2002, 2003). This proposed methodology, which we have named *intra-relational interventions,* extends into the client's intra-psychic world, AEDP's use of deep interpersonal contact, dyadic regulation of affect,

tracking of affective and somatic experience and focused reflection on experiences of transformation. We introduce an intensely relational model into the client's inner world because we believe that the mind operates "relationally" within the self much like it does interpersonally. Building on psychodynamic and object relations' theories (Hartmann, 1962; James, 1890; Jacobson, 1964; Kernberg, 1976) that posit the dual existence of subjective or experiencing selves alongside reflective or observing selves, we elaborate modes of intrapsychic relating between these two classes of self-states. Specifically, we propose that the various self-states occupying these two positions create *a matrix of internal attachment relationships, forming the basis for one's capacity for self-regulation and integration*. Developing this subjective-reflective dyad's capacity for reciprocal attunement, resonance, responsiveness and integration is a primary goal of intra-relational interventions.

While there are many clinical models for working with "parts" of the self in psychoanalysis (Assagioli, 1971; Federn, 1952; Jung, 1936) experiential psychotherapy (Berne, 1975; Moreno, 1997; Perls, 1951) and dissociative disorders treatment (Kluft, 1993; Putnam, 1989; Watkins & Watkins, 1997), integrating AEDP with self-state methodology introduces an attachment-based, relational focus that is under-utilized or absent in other methods. Specifically, Intra-relational/Intra-psychic interventions involve:

1) Evoking capacities for self regulation via deep, shared states of affective resonance between therapist and client, therapist and dissociated self-states, and client and self-states,

2) Initiating authentic, open, internal dialogue between self-states to resolve intra-psychic conflicts and engrained patterns of self punishment,

3) Developing self reflective and emotional processing abilities by bringing together previously disowned affects/emotional memories with here and now consciousness,

4) Fostering positive, healing affects associated with deep levels of understanding, compassion, and affirmation of self.

Intra-relational interventions evolve from a relational foundation of safety, trust, compassion and empathy, which is mindfully nurtured between the therapist and client, as well the therapist and disowned or dissociated client self states. Gradually, these pathways open up a new avenue of connection and understanding between the client and their own dissociated self-states [see diagram one]. Intra-relational interventions draw on AEDP's (Fosha, 2000) explicit attachment principles and relational techniques to actively foster secure attachment and improved emotional functioning between previously conflicted or estranged parts of the client's mind.

In this paper, we will discuss review attachment and developmental theories underlying intra-relational theory, as well as put forth our ideas on the relationship between subjective and reflective self-states. Then we review AEDP meta-psychology and methodology, and finally, propose the intra-relational treatment approach that unites AEDP and ego-state theory/therapy within a single clinical framework.

Attachment and Integration of the Self

Self psychology and attachment theory have elucidated ways in which affective and behavioral interactions between primary caregiver and infant become internalized, thereby molding the ongoing development and integration of the child's emerging self. These dynamics inform much of the metapsychology underlying intra-relational interventions. Of particular importance are Kohut's (1977, 1984) notions of selfobjects and transmuting internalization and Bowlby's concepts of secure base and internal working models (1969, 1988).

Kohut (1977, 1984) described the process by which caregivers function as "selfobjects," providing fundamental regulatory capacities for children whose own internal structures are still immature. Vital parental functions such as protection, soothing, drive modulation, affective awareness, and emotional regulation maintain the child's internal homeostasis. Over time, inevitable, non-traumatic empathic failures by even the most sensitive, attuned caregiver engender a process Kohut termed, "transmuting internalization." In transmuting internalization, the more mature child draws on his/her own capacities internalized over time from numerous dyadic encounters with caregivers. For example, a child whose anxiety and shame were adequately soothed and modulated by the mother would be able to self-soothe when such affect states are evoked in her absence. When a child experiences "good enough" parenting (Winnicott, 1965), the process of transmuting internalization and subsequent consolidation of internal emotional regulatory functions lays the crucial groundwork for a cohesive and robust self system.

John Bowlby also saw the relationship between caregiver and child as essential in developing an internalized "secure base" and mental representations that make meaning of reality (Bowlby, 1973; Bretherton, 1987; Fonagy, Gergely, Jurist, & Target, 2002; Main et al. 1985; Stern, 1995). According to Bowlby, attachment behavior is part of an innate biological system activated by the presence of threat or danger that motivates the vulnerable child to seek proximity to and protection from an older, stronger and wiser caregiver, thereby maximizing the chances of survival (Bowlby, 1969). Later models of attachment (Ainsworth, 1978; Main & Solomon, 1990) elaborated crystallized styles of relatedness shaped by early, repeated interactions with caregivers: secure, insecure (preoccupied or avoidant) and disorganized attachment. These styles of relatedness also led to the development of what Bowlby described as

"internal working models" (Bowlby, 1969; Bretherton, 1987; Main et al., 1985), internalized schemas of important attachment relationships. Consisting of feelings, expectations, beliefs, and behavioral routines, working models implicitly guide a child's (and later adult's) ability to respond to him/herself and the world.

In secure attachment, the child's access to a reliable, attuned, safe and predictable other builds a stable foundation of security and trust: a "safe base" from which to launch curious and energetic explorations of the environment (Bowlby, 1988). This emotionally supportive, coherent and open environment also leads to the development of internal working models of self and other that consistently and relatively accurately represent the person's current reality.

In disorganized attachment, chronic relational trauma and neglect cause a breakdown in organized attempts at coping with attachment dilemmas (Lyons-Ruth & Block, 1996; Main & Solomon, 1990). When a caregiver is abusive, frightening to the child, or exhibits dissociative or frightened affect in response to the child's distress, this gives rise to an insurmountable paradox, in which the child's attachment system compels him/her to seek safety from the very individual precipitating the fear or danger (Main & Solomon, 1990). This tragic double bind (Spiegel, in Blizard, 2003) presents the child with an irreconcilable conflict between the need for attachment and the need for protection, and gives rise to the style known as disorganized or "D" attachment (Main & Solomon, 1990). In a desperate attempt to avoid the inherent incoherence of meaning (e.g. "my dad is dangerous" and "my dad is my protector") and maximize the chances of psychological survival, children trapped in situations of maltreatment or neglect resort to the development of dissociated self-states in order to preserve attachment to the frightening caregiver (Blizard & Bluhm, 1994).

Thus, contradictory needs (attachment vs. protection), affects (relief vs. fear), behaviors (object-seeking vs. fleeing), and relational stances (approach vs. avoidance) can be segregated from one another within an increasingly disintegrated system of self-states. Each self-state incorporates divergent self and other representations, and may even encapsulate distinct attachment patterns (Blizard, 2003). The rapid shifting between poorly integrated self-states, each embodying different internal working models, offers a cogent explanatory model for the phenomenology of disorganized attachment. A common clinical manifestation of this is evident in the contradictory "come close/stay away" messages delivered by traumatized clients in crisis.

For abused and neglected individuals, chronic re-experiencing and avoidance of traumatic memories, combined with a deficient, fragmented self system, form a psyche that is unable to provide the soothing, self-regulation and integration of self-states required for adequate psychological functioning. Such vulnerability gives rise to primitive annihilation and disintegration terror; as Fairbairn described, "the terror of objectlessness" (in Grand & Alpert, 1993), floating in an abyss of isolation and hopelessness. In order to escape awareness of this state, the child disconnects in a "dead spot" of experience (Kestenberg in Schore, 2002) in which "both the subjective self and intersubjective field instantly switch off and do not exist" (Schore, 2002, p. 454). In essence, this represents the equivalent of infinitely re-experienced internal and external abandonment.

Looking at these psychological perspectives through the lens of self-states provides a powerful, albeit speculative, explanation for emergent patterns of self-organization. Intra-relational theory unites neurobiological evidence of self-state organization and dynamics with attachment and psychodynamic concepts in a model that describes how relational exchanges are internalized and codified into enduring patterns of self-relating. Specifically, we posit the

existence of *internal attachment relationships* between discreet self-states that mirror external attachment relationships in a given individual. This model opens up the possibility of intervening experientially in ways that directly alter pathogenic patterns of intrapsychic relating commonly found in clients with severe abuse and neglect histories.

Self states and the Intra-psychic Attachment System

The work of neuroscientists and clinicians such as Damasio (1999), LeDoux (1996), Schore (1994), and Siegel (1999) have underscored the importance of psychobiological "state" in understanding the mind-body connection, psychological development, personality, resilience and pathology. The term "self-state" refers to discrete experiences of subjectivity created when the brain links co-occurring somatic, affective, cognitive, and behavioral representations into a cohesive, functional whole (Siegel, 1999). While each state plays a role in self-organization, what is most important to psychological functioning is the mind's ability to integrate activity and functions across self-states (Izard, Ackerman, Schoff & Fine, 2000; Lewis, 2000).

The concept of internal representations, first proposed by Freud (1891/1953a) and later elaborated by object relations theorists (e.g. Hartmann, 1939; Jacobson, 1964; Kernberg, 1976), describes the psyche as being shaped by the interplay between the subjective experiences of self (self-representations), and internalized models of significant others (object representations). In the intra-relational framework, internal representations are organized into two general classes of self-states: those that generate our subjective experience in the moment, and others which reflect upon (Damasio, 1999; James, 1890), appraise and then regulate our response to that experience (Hartmann & Loewenstein, 1962; Schore, 2003). Together, their relationship forms an internal attachment system whose affective tone and functional capacities will, for better or worse, be analogous to those experienced with primary attachment figures.

We hypothesize that in secure attachment, intra-psychic relating between subjective self-states and reflecting self-states will generally mirror the positive affect, attunement, openness, and responsiveness experienced with attachment figures. Reflective self-states fulfill their function by "enacting" the internalized reflective and soothing functions of the attachment figure with the subjective self-state. This process leads to relatively rapid transitions out of distressing psychobiological states. We believe this securely attached, intra-psychic dyad forms the basis for a robust psychic structure characterized by high "psychological immunity" to distress (Holmes 2001), general coherence in affect, thinking and behavior, resilience, intact affect regulation and greater "response flexibility" (Siegel, 1999).

In contrast, for clients with disorganized attachment, intra-psychic relating among subjective and reflective self-states recapitulates the disengagement, abuse and inconsistency found in their relationships with abusive and neglectful caregivers. For example, a client's longings for closeness may be met by internal scorn or contempt in the form of persecutory voices (Firestone, 1997) or images emanating from a self-state in the reflective position. Rather than allowing for an adaptive response to the need for connection, this internal enactment moves the client into a dysphoric state of shame, aloneness and depressive helplessness.

The AEDP Treatment Model

Capitalizing on the enduring plasticity of the adult brain (Kandel, 1999), a psychotherapy that integrates and implements principles of healthy attachment, emotion and neurodevelopment possesses transformative and restorative potential in the face of profound deficits in self-structure. Accelerated experiential dynamic psychotherapy (AEDP; Fosha, 2000a, 2000b, 2002, 2003) uniquely embodies such characteristics.

AEDP is an integrative treatment model blending relational, psychodynamic, emotion, and experiential theories and treatment approaches, within a metapsychology informed by affective neuroscience and attachment theory. The primary goal of AEDP is to evoke in clients a resilient psychological state (i.e. "self-at-best;" Fosha, 2000) through which they can viscerally experience adaptive emotional responses ("core affect" Fosha, 2000) that, due to trauma and/or repetitive attachment failure, have been dissociated from consciousness. AEDP interventions feature moment-to-moment accessing, experiential tracking and processing of core emotional experiences such as grief and rage. The working through to completion of core affective sequences activates innate self-righting mechanisms, adaptive action tendencies, and internal resources that support optimal psychological functioning (Fosha, 2000a, 2000b, 2002, 2003).

AEDP interventions follow a trajectory of three states and two state transformations [see diagram 2]. When a client's defenses are successfully bypassed or restructured (e.g. McCullough-Vaillant, 1997) and core affect is released and shared within an attuned, therapeutic relationship, a wave of calm, clarity and inner wisdom that Diana Fosha (2000) refers to as "core state" washes over the client. Core state is a transcendent plateau characterized by deep relaxation and inner vitality, openness to self and other and possibility, as well as fluid, unimpeded expression of subjective experience.

A common clinical manifestation of this transformative power of emotion can be seen in a survivor of physical abuse, who, as a child, learned painful, terrifying lessons that anger is dangerous and destructive. As an adult, she indiscriminately disavows any internal experience of anger and is thereby robbed of resources geared toward self-protection, empowerment and ability to negotiate and defend interpersonal boundaries. In the absence of anger's adaptive information and action tendencies, she is exquisitely vulnerable to re-victimization (Gleiser, 2003).

Complicating this picture, the dissociated anger that is diverted from the relational field does not disappear; rather it may be turned viciously against the self via criticism, self-hatred, and covert self-sabotage.

To address such dynamics, AEDP interventions help the client track subtle somatic indicators of suppressed or misdirected anger and then initiate experiential exercises designed to release the anger toward its original source (most often the actual perpetrator) (Fosha, 2000). Hence, the individual is reunited with a sense of personal power, the right to assert her own needs for self-protection and care, and outrage against the injustice done to her, instead of staying doomed to internally recapitulate the abusive dynamic while remaining undefended against threats from others.

However, many traumatized clients present for treatment in the throes of longstanding affect phobias (McCullough-Vaillant, 1997), having learned painful lessons that intense affect plus desperate aloneness equals what Fosha (2002, 2003) calls unbearable states of overwhelming distress. Such clients learn to avoid being immersed in core affect at any cost. AEDP uses an elaborated set of relational interventions to address the clients' defensive avoidance of the very experiences that catalyze healing and transformation.

Although treatment alliance has been identified in process-outcome literature as the most robust and consistent predictor of treatment success (e.g. Orlinsky, Grawe & Parks, 1994), it typically remains a nonspecific factor in most therapeutic models, with a dearth of well-articulated theories and techniques to guide its development and focused application in sessions. Interpersonal theorists and relational psychoanalytic models also emphasize the centrality of relationships and the therapeutic alliance (e.g. Stiver & Miller, 1995), especially for trauma survivors, whose relational templates are severely disrupted by betrayal, abuse and neglect

(Briere, 2006; Davies & Frawley, 1994). In AEDP, much emphasis is placed on building and nurturing the therapeutic relationship. Eye contact, body language, affective matching, contingent communication, authenticity of expression and other interpersonal variables are tracked as closely as the emergence of affect, facilitating the therapeutic dyad's shared sense of trust and safety (Safran & Muran, 1996). When relational defenses against closeness impede connection, the therapist acknowledges and appreciates them as important, *old* protective strategies, and encourages the client to test whether they are necessary in the current relationship by in the moment monitoring of therapist verbal and nonverbal communications and reactions toward the client.

All experiential and reflective clinical work in AEDP occurs within the context of an emotionally attuned, supportive, authentic, relationship with the therapist (Fosha, 2000, 2003). Placing a focus on relational safety provides a "secure base" for the experiential exploration of the client's psychological landscape. Shared states of deep affective attunement facilitate the regulation of emotional experience *within the dyad*. The therapist creates a "holding environment" (Winnicott, 1965) and temporarily fulfils the selfobject function of externally regulating experiences that feel out of control to the client (Kohut, 1984), especially pathogenic, inhibitory affects such as shame and fear. Once accessed, the dissociated material can be witnessed, both by the therapist and, as we will explore in the following section, by the entirety of the self-system, then metabolized, transformed and re-integrated. In the process, the client learns to reflect on his/her experience, and create an adaptive appraisal of meaning on the previously dreaded primary emotions.

This mutual process of building trust fosters multiple ego strengthening capacities within the client. In addition to undoing painful aloneness and garnering courage to access dissociated

material, this process restructures attachment, re-working archaic patterns of insecure or disorganized bonds and breaking chronic relational re-enactment cycles (Blizard, 2003; Gleiser, 2003). Reiterative experiences of attunement and affective coordination between therapist and client advance the client's internal capacity for affect tolerance and psychological resilience (Trevarthen, 1993; Tronick, 1998, 2003). Furthermore, the therapist's sustained focus on client's strengths and progress through affirmation and enthusiastic celebration is the cornerstone for internalization of compassionate, caring and attuned relating to oneself. The therapist's deep empathy and emotional engagement with the client models an "optimal responsiveness" (Conners, 1997) which renews faith in the healing power of relationships, and teaches the client more effective ways of tracking and responding to their own needs for care and soothing. The genuine and deep flow of emotional communication between therapist and client gives rise to a mode of relating "beyond mirroring" (Fosha, 2000), a term which captures the co-creation of a novel, transformative and shared space extending beyond mere reflection.

AEDP's twin strands of experiential and relational interventions spiral in an ever-deepening synergy: heightened safety in the relationship leads to joint venturing further into the client's intra-psychic experience. Once the fruits of this labor are reaped (i.e. negative affect is shared and transformed into strength and mastery), this feeds into an evolving intimacy and greater sense of security that initiates the next round of experiential work (Fosha, 2003).

The Intra-relational Field

In an ideal world, the therapeutic process would unfold seamlessly along the lines depicted above. However, most clients with histories of severe trauma and neglect exhibit poor affect tolerance, dissociate under stress, harbor significant distrust of others and therefore, avoid

contact with feared to be unbearable affective states at all costs (Gold, 2000). If gently pressured toward a fuller experiencing of dissociated affect, such clients often oscillate between extremes of constriction, numbness, deadness and detachment from self and therapist, to floods of dysregulated pathogenic affects, including intense shame, fear and aloneness (Gold, 2000).

Intra-relational interventions address fragilities and risk factors that can sabotage therapeutic progress by building on AEDP's foundation of dyadic regulation, affective attunement, empathic engagement and experiential attending. Intra-relational interventions bring these healing elements to bear on the client's disjointed and conflicted intra-psychic world. When sequelae associated with disorganized attachment and chronic abuse causes profound psychic dissociation, emphasis is placed on facilitating experiential engagement between the client and the client's heretofore dissociated internal system of self-states.

In order to illustrate intra-relational interventions in an experience-near modality, we present a case that embodies many of the core assumptions and applications of this evolving methodology.

Clinical Case Example: "The Voice behind the Wall"

Julie[1] is a twenty four-year-old, married, Caucasian woman. She was severely physically abused and terrorized by a mentally ill older brother from infancy through adolescence, with her parents never intervening to protect her or acknowledge the abuse. Family dynamics were characterized by profound neglect and sexual abuse. Julie exhibits symptoms of complex PTSD and meets criteria for a dissociative disorder (DDNOS; Dissociative Disorder Not Otherwise Specified). Although she is aware of distinct, disowned self-states, she does not report lost time or experience loss of executive control over daily activities.

The following segment is taken from a therapy session that occurred about four months into treatment. Julie began the session reflecting on her difficulty taking care of herself, meeting her own physical and emotional needs and procuring nurturance from others. I (KG) drew the parallel between neglect she suffered as a child and the perpetuation of this dynamic internally. Just prior to the beginning of this transcript, Julie had been describing her anger toward her mother in regard to the profound neglect she experienced as a child. However, her tone was flat and robotic, with an absence of any physiological arousal associated with the experience of anger. This segment begins with my drawing attention to the defensive processes inhibiting anger, which leads to the discovery of an abandoned and feared self-state that holds concentrated reservoirs of intense affects, both anger and despair. As the session unfolds, Julie initiates an encounter with this disowned self-state, tracking, with my prompts, the emergence of divergent visual, affective and somatosensory experience housed in different self-states. Her intra-relational dynamics evolve from fear and rejection into care, compassion and emotional release. This segment illustrates the repair of an internal rupture, and little step by little step development of trust, emotional attunement, and empathy between previously estranged self-states.

K: As you start to say this Julie, what are you experiencing inside? *(directing attention to internal experience)*

J: It makes me really tired.

K: Mmm. Cause your voice is getting softer and more strangled as you talk more. *(recognizing defensive avoidance of affect)*

---

[1] All identifying information has been changed to protect the anonimity of the client. This segment was transcribed from a videotaped session. The client gave signed consent to release the videotaped session to be used for educational purposes.

J: I feel it in my throat. Sometimes when I think about it I just want to go to sleep. *(dissociation of experience of anger)*

K: It's clearly very hard for you to let yourself really feel the anger when you say this. Cause I kinda know that it's in there, but I don't feel it. What I feel is a withdrawal. (*tracking emotional experience, or lack thereof, in Julie)*

J: I don't know what to do.

K: I think we need to stay very attuned to what you're feeling. What do you feel inside your body right now? *(tracking somatic experience to bypass defenses and connect with affect)*

J: My head hurts. I feel it right here (grabs necks). It's all tight.

K: What do you think it is that's all bound up in there, strangling your throat and causing all that pain in your head, if you focus on those feelings for a moment?

J: I'm just so angry with her, but I don't *feel* angry, I just know I'm angry. *(dissociation between cognitive and affective elements of experience)* Like there's a different person inside me that's angry and that's telling me that I'm angry. *(acknowledgement of disowned self-state that "holds" the anger)*

K: Hmm. Tell me more about that other person.

J: They're very angry, but for some reason they're trapped, and they have no voice, so they have to tell me what they're thinking and it's telling me that I'm so used to being angry that I'm not angry anymore. . . . (tells also about a persistent sad part of her).

K: How do you feel about these parts of you, this really angry part and really sad part? *(eliciting baseline response to dissociated self-states as a precursor to enhancing receptivity)*

J: I do feel that they are separate. I want to get rid of them! And just have me. Not have to worry about that stuff. *(rejection of self-state that holds feared emotional experience)*

K: Do you have a sense of how they feel, hearing you say that you want to get rid of them? *(encouraging tracking of self-states response; precursors of empathy and attunement)*

J: It hurt their feelings.

K: I wonder if you have a sense of how it feels to have that angry part of you acknowledged, just being welcomed into the room in a certain way, by me, you know and acknowledged and seen. *(therapist extending welcome and building alliance with self-state)*

J: I picture a fence up. And I don't have a key to open it and let that person out. I had to put a fence up or it would burst through when I don't want it. *(symbolization of dissociative barriers)*

K: What kind of fence is it? What do you envision? *(encouraging the use of vivid, metaphorical imagery)*

J: It's a high wooden fence.

K: It's to protect you from this part of you. (*highlighting adaptive motivation of the defense)*

J: Yeah, but it's made of wood, so it could be broken. *(emotional "truth" of the fragility of this defensive structure)*

K: Umhm. So it's very fragile protection.

(Deleted segment about how Julie receives communication from this self-state. She describes a flashback of brother cutting her face with scissors and mother ignoring her bleeding mouth).

K: It sounds horrific, not only that he would do that to you . . . . but that again, you got that response from your mother, no care-taking, no help, no support . . . . Such a desolate image (said with emotion in therapist's voice). I mean, it so much sums up that neglect. (sigh) And quite frankly, it makes me feel enraged that your mother would turn you away like that. It's appalling to me. *(therapist disclosure of emotional reaction)* So actually, I am quite in agreement with this part of you that holds the anger. *(allying with dissociated self-state)* I wonder, Julie, without

letting everything free, without tearing down the gate or fence, is there any way that you and I might enter into communication with this angry part of you in a safe way right now. If there's any way we could approach or have contact with that part of you. *(encouraging contact between self-states)*

J: We can try.

K: How do you imagine that would happen? Using this image of the fence.

J: There's a fence and something else holding back where I can't see the person or whatever it is, I can't see it's face. Like in Silence of the Lambs, where they're held and wrapped up so they can't move. *(imagery communicates intense fear and a need to keep the emotions locked up in restraints)*.

K: So that would feel safer to you if that part of you were contained like that? So let yourself imagine that kind of safety and containment around this part of you. And I guess first, I would want to know how this part of you feels about being present here in any way. *(eliciting her tracking the emotional response of the disowned self-state)*

J: It's like, they're, she's, their head is tr- trying to frail - flail about, but they can't.

K: How do you feel seeing that? *(simultaneously tracking her emotional reaction)*

J: Scared. I'm picturing myself opening the fence and walking in there, keeping far away, and just looking at that part of me.

K: What do you see?

J: They're just trying to yell, crying, just so upset.

K: What might that part of you need to feel calmed, soothed and reassured? Because it's such a distressing image to me that there is this part of you that is so frantic and panicked it sounds like,

and just desperate. *(entraining care-taking capacity toward the self-state; therapist self-disclosure of emotional response to distress)*

J: (long pause). I feel like slowly going over and hugging myself, or that person, and slowly taking off the wraps and seeing, can I trust you to have your arm free? Can I trust you to have your mouth free to talk? *(little step by little step building of trust between self-states)*

K: So if you were to do that very slowly and gradually, and let's very much stay in communication with that part of you, tell me what you see as you approach and start asking for that reassurance and freeing slowly, piece by piece.

J: (eyes closed in spontaneous trance state, absorbed in inner drama) At first they're fighting me when I hug them. And I just keep hugging them and tell them that I love them, no matter what happens. And then I . . . uncover its mouth. And I don't hear words; I hear frustrated sounds and crying. And I'm petting their head.

K: What are you saying to her?

J: It's OK. I care about you, enough to let you free, and enough to trust you . . . with myself.

K: And how does she respond now that her mouth is free?

J: She's just crying, really hard crying, so much she can't talk.

K: Are those tears of sadness, or relief, or anger? What are those tears saying do you think?

J: They're so upset about what happened, and finally someone is listening (K: mmmnn) to all the despair. *(undoing of tragic aloneness)*

K: Finally, she has you. What do you see next?

J: I let her out completely and she falls to the ground and I catch her. And I have no expression. *(emotional constriction persists in Julie)* I'm just holding her.

K: How does it feel in her body to be held by you?

J: It feels strange, but good.

K: And how does it feel in your body to do that holding? How do you see yourself holding her?

J: I'm laying on the ground and holding her with my arms.

K: How does it feel inside of you to do that?

J: Feels like I'm helping her. Feel kind of hopeless, like I can't help her all the way.

K: Mmmnn.

J: Like she's messed up for life.

K: Can you let yourself take in her reaction? Because from what you said, this feels very good to her. Feels strange, but good. How do you know that from her? How do you know that feels good? *(encouraging her to read positive cues from self-state instead of making assumptions; deepening the impact of one on the other)*

J: She's not trying to get away.

K: How does her body feel in your arms?

J: So tight and cold, and bony. She's sensitive to touch, b/c she's in so much pain, that I have to be very careful that I'm not moving my arms. I don't want to hurt her.

K: You're very tender with her. How does it feel for her to be treated so tenderly? What is happening inside of her as she's finally getting taken care of, this pain-filled, ravaged part of you? *(both emphasizing/praising care-taking capacities, and tracking the impact on the dissociated self-state)*

J: She's so skinny and so frail, and . . . she's just, she's just can't stop crying (voice breaks). She can't say enough how much it hurt, it hurts. She's thinking about all the times when she needed what she's having right now, and never got it.

K: Is she still able to take in the feel of your arms and the feel your presence near her as she's crying so hard?

J: She's feeling it like I'm allowing her to cry like that. *(presence of an internal secure attachment object allows the distressed self-state to experience grief and emotional release)*

K: What about having you near lets her cry like that?

J: She's just so desperate to have someone to cry to. She's calming down, cause she's so tired. And I get a nice big blanket for her and a pillow, and I hold her while she falls asleep.

K: Hmm. You are such a good caregiver. You are so attuned to her needs. So sensitive to her.

. . . .

(at the end of session)

K: You really, for time, have had the courage to approach something that has been very scary for you. . . that's felt very potentially out of control.

J: Yeah.

K: I wonder, looking back on it now, where you've come from a half hour ago, when you were so afraid that this part of you had to be in constraints and behind wooden gates, locked up; how are you feeling toward this part of you now? *(reflection on meta-transformative process to consolidate new, emerging relational dynamics and affects)*

J: I feel bad that I was scared of her. I just misunderstood her. *(restructured belief about a part of the self)*

This session traces a pathway from self-neglect to dawning self-compassion and internal witnessing. Julie's attuned soothing, recognition and care-giving emerging by the end of the session stands in stark contrast with her initial statement about how she does not take care of her

own needs. Another notable characteristic of this intra-relational intervention is the accessing of unique affective and somatic components experienced by different self-states. This corresponds to Nijenhuis' theory of structural dissociation (Nijenhuis, van der Hart & Steele, 2004), which conceptualizes the traumatized individual as split into an ANP (apparently normal personality) and an EP (emotional personality). Although Julie develops a nurturing/protective stance toward a self-state mired in despair, desperate aloneness and rage, allowing for the full experiencing of core grief, she herself remains constricted and somewhat aloof from affect. She does appear to undergo an undoing of pathogenic fear of a part of herself and gain mastery over handling intense feeling, but this is only the first step in a process that will (hopefully) one day entail the re-integration of the emotional experience into her core sense of self.

Intra-relational Interventions: Overview of goals and interventions

Utilizing the raw clinical material of this case as a foundation, we now embark on a more detailed theoretical discussion of the underpinnings and objectives of intra-relational interventions.

1) Creating a safe, secure, responsive internal holding environment.

As we mentioned earlier, one of the most enduring legacies of severe trauma and neglect is that intrinsically disorganizing experiences of persecution, helplessness and emotional abandonment serve as persistent procedural templates for the survivor's style of self-relating. Apropos of this, Fosha (2000, p. 233) describes psychopathology as: "the result of the individual's unwilled and unwanted aloneness in the face of overwhelming emotions." We propose that an analogous "unwilled and unwanted aloneness," occurs *intra-psychically* when survivors are flooded with intense affects. Many survivors have limited ability to compassionately bear witness to their internal experience. Either they are so consumed by

overwhelming emotions that no reflective self is available to intervene and provide self regulatory functions, or the reflective self reacts with persecutory responses (Firestone, 1997). As one trauma survivor put it when the second author (KG) slowed her down from a rote description of past sexual assaults and prompted her to attend to her inner experience in the moment: "I've told this story to so many people in the past year that I'm used to just saying it. But I've never said it to myself." Her inability to bear witness to her own pain went far in explaining how she could say she "felt nothing" while desperate tears were coursing down her cheeks for the entire session.

A primary goal of intra-relational interventions is to undo this internal aloneness by fostering reliable presence and proximity between therapist, client and segregated self-states. This goal is achieved first through the therapist's awareness of what is disowned, recognition of the resultant alienation from crucial aspects of self experience, and then through the gradual attunement between the client and her own dissociated self-states (Bromberg, 1998; Fonagy et. al., 2002). Extending Fosha's clinical ideas regarding interpersonal coordination of affective states (2000, 2002, 2003) to work with self-states, we believe that it is the deep, genuine, and open emotional involvement *between clients and their inner world* that "cures" because *it is precisely the clients' withdrawal from the process of mutual coordination between self-states (through dissociation),* which *now* perpetuates the aloneness, terror and affective avoidance. As Julie's experience illustrates, her fear-induced confinement of the self-state flooded with feelings of anger and despair led not only to a segregation of the affects, but also a rejection and neglect of the self-state associated with those feelings. When Julie was able to embrace this part of her and help her feel less alone, the result was a release of long pent-up grief and an opportunity to experience both care-taking and feeling taken care of.

Intra-relational interventions essentially import relational strategies (Fosha, 2000) from the interpersonal domain into the client's disjointed and conflicted intrapsychic world. By integrating the use of visual imagery, internal dialogue and other techniques associated with "parts work" (Assagioli, 1971; Fraser, 1991; Jung, 1936; Kluft, 1989; Moreno, 1997; Perls, 1951; Schwartz, 1995; Watkins & Watkins, 1997; Paulsen, 1995; Forgash, 2005; Bergmann, 2005), intra-relational techniques help the client acknowledge, experientially process and assimilate disowned/dissociated experiences. Often, this process is mediated first by the therapist's attending to and empathizing with disowned emotion, impulses, memories, behaviors in dissociated self-states. For example, my highlighting and identifying with the part of Julie that feels angry at her family was both an invitation and rapprochement to that self-state, as well as an entraining of Julie's empathy and recognition toward that self-state. Here, the first two relational pathways (i.e. therapist-client and therapist-dissociated self-state) created a bridge to the third pathway (i.e. client-dissociated self-state) forging a new an internal working model that encompasses both self-states (Blizard, 2003, Schwartz, 1995). Through the mutual attunement between therapist, client and self-state, dissociated experiences of anger, shame, anxiety, and aloneness are attenuated and re-consolidation of dissociated experience into the client's autobiographical narrative can begin (Fosha, 2003).

2) Resolve internal conflicts by repairing perennial "ruptures" between polarized self-states

Establishing an internal climate of attunement, respect and responsiveness allows for the reconciliation of conflicts between self-states operating within polarized models of attachment (Blizard, 2003). Internal systems characterized by years of rejection, isolation, alienation, and uneven distribution of painful, traumatic material (e.g. self-states who are burdened with the majority of traumatic memories/affects and then ignored by the rest of the self), show the strain

of accumulated resentment, resignation, and even rage (Schwartz, 1995). Hence, Julie's image of her dissociated self-state as initially writhing with rage and needing to be restrained in isolation from the rest of her. In other survivors, these negative relational dynamics can manifest in extreme behaviors such as self-sabotage, ”inflicting” intrusive flashbacks as revenge for “being ignored”, acts of aggression against the self, re-enactments, (Gleiser, 2003; Firestone, 1997) and even, in the case of dissociative identity disorder, homicidal alters who act out via threats and harm to self or others. In a later session that same month, Julie spontaneously described how another ignored self-state bearing many of her traumatic memories often inflicts physical pain on her body as revenge for being neglected.

Therefore, a key focus of intra-relational interventions involves brokering relational repairs of age-old conflicts and mediating conflict resolution between self-states (Kluft, 1989; Watkins & Watkins, 1995). This parallels the kind of rupture/repair/re-coordination sequences that unfold between secure mother-child and therapist-client dyads (Trevarthen, 1993; Tronick, 2003). Specific techniques lead clients to engage in inner dialogue and visual imagery (Fraser, 1991; Paulsen, 1995; Schwartz, 1995; Bergmann, 2005; Forgash, 2005), where explicit acknowledgement, empathy and reflection are used to both validate the *past* expediency of particular survival strategies and to invite cooperation in adapting to present conditions During this process, the therapist assumes an active role in the provision of safety and the regulation of fear and anxiety -- which often underlie most of the ruptures (e.g. rejection, avoidance, and aggression) that maintain isolation and hostility between parts of the self (Fosha, 2000, 2003). Essentially, this promotes the re-structuring of internal attachment relationships between self-states, replacing old models characterized by abuse, neglect and abandonment, fear and aggression, with new models defined by empathy, cooperation, nurturance and compassion

(Blizard, 2003; Schwartz, 1995) . Julie's case illustrates how the use of inner dialogue and vivid imagery creates new emotional experiences in session, which serve as building blocks for revised internal attachment templates.

In addition, another important goal is helping clients to hold online simultaneously both poles of conflicting needs until a compromise can be divined, slowly replacing the tendency to swing wildly and exclusively between them (Bromberg, 1998). For example, when a regressive, needy, help-seeking self-state initiates contact with the therapist, this can immediately elicit a protective, resentful, rejection-sensitive self-state that feels compelled to ward off intimacy and potential hurt. This confusing push-pull dynamic often results in multi-dimensional communications that must be carefully disentangled so that each self-state's experience can be identified and respectfully responded to accordingly (Bergmann, 2005; Forgash, 2005; Paulsen, 1995; Schwartz, 1995; Watkins & Watkins, 1995). Failure to do so can catapult therapist-client dyads into dreaded but inevitable re-enactments that alienate the client from a source of available support and frustrate the most well-meaning therapist (Gleiser, 2003). In this case, an intra-relational intervention may foster direct dialogue between these two self-states, who embody very disparate, but equally valid imperatives. With the guidance of the therapist, the client is encouraged to appreciate and validate both sets of motivations, and to seek a solution that meets both sets of needs, as opposed to categorically dismissing one or the other.

Our clinical experience is that this type of direct engagement and intra-relational reconciliation often leads to rapid ego strengthening, greater resilience and enhanced ability to respond to complex situations in a desired manner. In common parlance, this allows clients to, in the words of another survivor, "stop being my own worst enemy," and to ally with consciously endorsed treatment goals.

3) Experiential co-mingling, tracking and cohering of present consciousness with previously dissociated self-states

Intra-relational interventions involve moment-to-moment attending to the affective/somatic states of *both* the client *and* dissociated self-states (Bergmann, 2005; Forgash, 2005). For example, in the case study cited above, at several different moments, Julie and the dissociated self-state exhibited *different subjective somatic experiences at the same time.* While Julie was initially full of fear and apprehension, the self-state in restraints was experiencing intense rage, distress and despair. Later, when the self-state was feeling "good" in Julie's arms, not struggling against her, but beginning to relax into the care, Julie was constricted, restrained, and feeling hopeless about being able to help her. At this point, shifting Julie's attention to the positive bodily cues emerging from the self-state helped her to attend to the true state of the "other," while simultaneously revising her own belief system around her ability to help.

We are not suggesting that two distinct “people” occupy the mind/body of this client or any other; however if the mind can simultaneously represent several discrete points of view and multiple complex schemata such as mental models, it is reasonable to assume that it can also represent multiple body maps as well. Teaching clients to attend to these distinct psychobiological states seems to help integrate “not me” affects and visceral sensations from the past into present day autobiographical narrative (Bromberg, 1998; Chefetz & Bromberg, 2004; Fonagy et al. 2002).

Another important aspect of self-state specific experiential tracking/processing involves the issue of receptivity. In AEDP, it is standard practice to have clients reflect on their secondary experience of the emotional processing in the context of the therapeutic relationship (Fosha, 2000). This can help facilitate the next round of processing and to solidify gains from the

experiential work. Typical phrases might include “What was it like for you to express your sadness here with me?”

In intra-relational work, this type of inquiry is extended to the world of internal self-states. In the case of Julie, for example, the therapist wonders, “You’re very tender with her [i.e. the dissociated self-state]. How does it feel for her to be treated so tenderly? What is happening inside of her as she’s finally getting taken care of, this pain-filled, ravaged part of you?" In addition to deepening the connection between Julie and the separated self-state, focusing on the self-state’s response often yields valuable feedback as to whether the experience has been “taken in,” and emotionally metabolized (Fosha, 2000). Aside from Julie’s own growing sense of mastery as a competent, attuned caretaker, the newfound intimacy and connection deeply affected the self-state by allowing a release of core grief ("She’s feeling it like I’m allowing her to cry like that.") that ultimately flowed into a calm sleep, thereby implying a profound sense of safety and protection in the presence of the formerly avoidant/rejecting Julie. This meta-experiential processing confirmed that some re-structuring occurred within both Julie and the dissociated part of her, as well as in the attachment relationship between the two parts of the self.

4) Fostering positive affects associated with heightened resonance between self-states, and change-for-the-better

Assessing the client’s and internal self-states’ receptivity to the process of transformation and experientially exploring positive affects associated with these changes are important elements in the intra-relational process (as in standard AEDP; Fosha, 2000a, 2000b).

> “The therapist’s emotional presence and affective responsiveness are crucial in fostering a different learning process. . . . *For full therapeutic benefits to accrue**, the patient must recognize and experience** the therapist’s presence and responsiveness. They cannot merely be given by the therapist; they have to be received by the patient.” (Fosha, 2000, p. 234).*

We have found that connection with oneself and with others often creates a "double-edged sword" for survivors. While some self-states may possess powerful strivings to be heard, acknowledged and cared about, "being seen" also often brings with it anxiety provoking memories of predation, intense fears of abandonment, a sense of unworthiness, desperate feelings of dependency, self loathing for having dependency needs, and/or intense pain/grief in now receiving what has been needed but rarely if ever received in childhood (Blizard, 2003). Here, frequent re-iteration of interventions involving dyadic regulation of affect, empathy, support and titration in the intensity of intimacy may be required before the client can avail themselves of the transformational power of these inter- and intra-subjective encounters.

As clients gradually become better able to tolerate the experience of closeness with self (and others), the therapist helps them experientially attend to positive affective states associated with security within a trusted attachment relationship, relief as tragic aloneness recedes, or the validation of sharing dreaded emotional states (Fosha, 2000b).

In the case of Julie, meta-therapeutic processes would entail highlighting, on the part of the self-state, feelings and somatic correlates of release of grief, relaxation into being nurtured and understood by another. Furthermore, the therapist might praise Julie's courage and risk-taking in facing a feared, previously dreaded part of the self, reflecting on how Julie felt hearing the praise and identifying with being brave (e.g. whether she was able to admit and delight in the praise and positive affects, or whether they evoke anxiety and subsequent defending against).

Often, trauma survivors struggle as much against feeling positive affects as they do against negative ones. Shame or fear of loss/destruction and envy can bind and/or block such experiences from conscious awareness. If left unaddressed, such defenses can sabotage the hard-earned rewards of therapeutic gains, depriving clients of the pay-off of positive feelings of joy,

pride, comfort, intimacy and connection. Therefore, increasing a client's tolerance for positive affects and relational experiences is essential in broadening the horizons of her emotional repertoire and reinforcing adaptive internal re-organizations.

Summary

In this paper, we presented new theory and clinical techniques for working with chronically traumatized, neglected and dissociative clients. Intra-relational interventions have evolved through the synthesis of AEDP and ego state methodology. Primary objectives are to mobilize internal resources, build ego strength, and enhance self-compassion in fragile, depleted and/or low functioning trauma survivors. Intra-relational interventions are predicated on the notion of *(an) internal attachment relationship(s)* between dissociated self-states, which recapitulate an individual's external attachment history. Specific clinical techniques import explicit relational interventions (Fosha, 2000) in order to guide an accelerated transformation from internal disorganization, abuse and neglect to self-responsiveness, empathy, nurturance and compassion. Intra-relational interventions are designed to facilitate "secure self-attachment" within clients, which allows for deeper emotional processing and accelerated resolution of traumatic experiences.

Works Cited

Ainsworth, M.D.S., Blehar, M.C., Waters, E. & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum.

Assagioli, R. (1971). *Psychosynthesis: A Collection of Basic Writings.* NY: Penguin Group.

Bergmann, U. (2005). In C. Forgash & M. Copeley (Eds.). *Healing the Heart of Trauma: Integrating EMDR and Ego state Therapy*. (Manuscript)

Berne, E. (1975). *Games People Play: The Psychology of Human Relationships*. New York: Random House.

Blizard, R. A. (2003). Disorganized attachment, development of dissociated self-states, and a relational approach to treatment. *Journal of Trauma and Dissociation, 4* (3), 27-50.

Blizard, R. A. & Bluhm, A. M. (1994). Attachment to the abuser: Integrating object relations and trauma theories in treatment of abuse survivors. *Psychotherapy, 31* (3), 383-390.

Bowlby, J. (1973). *Separation*. New York: Basic books.

Bowlby, J. (1969). *Attachment and loss, vol. 1: Attachment.* New York: Basic Books.

Bowlby, J. (1988). *A secure base. Clinical applications of attachment theory.* London: Routledge.

Bretherton, I. (1987). New perspectives on attachment relations: Security, communication and internal working models. In J. Osofsky (Ed.), Handbook of infant development (2nd ed., pp.1061-1100). New York: Wiley.

Briere, J. & Scott, C. (2006). *Principles of Trauma Therapy: A Guide to Symptoms, Evaluations, and Treatment.* Newton, MA: Professional Books.

Bromberg, P.M. (1998). *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation.* Hillsdale NJ: The Analytic Press.

Chefetz, R.A. &, Bromberg, P.M. (2004). Talking with "Me and "Not-Me: a dialogue. *Contemporary Psychoanalysis, 40* (3), 409-464.

Conners, M. E. (1997). Need and responsiveness in the treatment of a severely traumatized patient: A relational perspective. *American Journal of Psychotherapy, 51* (1), 86-101.

Damasio, A.R. (1999). *The Feeling of what happens: Body and emotion in the making of consciousness.* New York: Harcourt Brace.

Davies, J. M. & Frawley, M.G. (1994). *Treating the Adult Survivor of Childhood Sexual Abuse.* New York: Basic Books.

Firestone, R. (1997). *Combating destructive thought processes: Separation theory and voice therapy.* Thousand Oaks, CA: Sage.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). Affect regulation, mentalization and the development of the self. New York: Other Press.

Forgash, C. (2005). The Therapeutic Triad: Applying EMDR and Ego state Therapy in Collaborative Treatment. In C. Forgash & M. Copeley (Eds.). *Healing the Heart of Trauma: Integrating EMDR and Ego state Therapy*. (Manuscript)

Fosha, D. (2000a). *The transforming power of affect: A model of accelerated change.* New York: Basic Books.

Fosha, D. (2000b). Meta-therapeutic processes and the affects of transformation: Affirmation and the healing affects. *Journal of Psychotherapy Integration, 10,* 71-97.

Fosha, D. (2002). The activation of affective change processes in AEDP (Accelerated Experiential-Dynamic Psychotherapy). In J.J. Magnavita (Ed.). *Comprehensive Handbook of Psychotherapy. Vol. 1: Psychodynamic and Object Relations Psychotherapies*. pp. 309-344. New York: John Wiley & Sons.

Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disorganized attachment. In M. Solomon & D. J. Siegel (Eds.). *Healing Trauma: Attachment, mind, body and brain.* pp. 221-281. New York: W.W. Norton.

Fraser, G.A. (1991) The dissociative table technique: A strategy for working with ego states in dissociative disorders and ego state therapy. *Dissociation, 4* (4), 205-213.

Freud, S. (1953). On aphasia. E. Stengel (Trans.). New York: International Universities Press. (Original work published 1891)

Gleiser, K. A. (2003). Psychoanalytic perspectives on traumatic repetition. *Journal of Trauma and Dissociation, 4* (2), 27-47.

Grand, S. & Alpert, J. L. (1993). The core trauma of incest: An object relations view. *Professional Psychology: Research and Practice, 24* (3), 330-334.

Hartmann, H. (1939). *Ego psychology and the problem of adaptation*. New York: International Universities press.

Hartmann, H., & Loewenstein, R.M. (1962). Notes on the superego. *Psychoanalytic study of the Child, 17*, 42-81.

Holmes, J. (2001). *The search for the secure base: Attachment theory and psychotherapy.* East Sussex: Brunner-Routledge.

Izard, C., Ackerman, B.P., Schoff, K.M., Fine, S. (2000). Self-organization of discrete emotions, emotion patterns, and emotion-cognition relations. In M. Lewis & I. Granic (Eds.). *Emotion, Development, and Self-organization: Dynamic systems Approaches to Emotional Development.* pp. 15-36. Cambridge: Cambridge University Press.

Jacobson, E. (1964). *The self and the object world.* New York: International University Press.

James, W. (1890). *Principles of psychology*. New York: Henry Hol.

Jung, C. G. *The Collected works of Carl Jung*, vol. 8. (1936) Translated by R.F. C. Hull. Bollingen Series XX. Princeton University Press.

Kandel, E. R. (1999). Biology and the future of psychoanalysis: A new intellectual framework for psychiatry revisited. *American Journal of Psychiatry, 156* (4), 505-524.

Kernberg, O. (1976). *Object relations and clinical psychoanalysis*. New York: Jason Aronson.

Kluft, R. (1989). Playing with time: Temporizing techniques in the treatment of multiple personality disorder. *American Journal of Clinical Hypnosis. 30*, 257-266

Kohut, H. (1984). *How Does Analysis Cure?* Chicago: The University of Chicago Press.

Kohut, H. (1977). *The Restoration of the Self.* New York: International Universities Press.

Lewis, M. (2000). Emotional Self-Organization at three time scales. In M. Lewis & I. Granic (Eds.). *Emotion, Development, and Self-Organization: Dynamic systems Approaches to Emotional Development*. Pp. 15-36. Cambridge: Cambridge University Press.

LeDoux, J. (1996). *The emotional brain: The mysterious underpinning of emotional life.*

New York: Simon and Schuster.

Lyons-Ruth, K., & Block, D. (1996). The disturbed caregiving system: Relations among childhood trauma, maternal caregiving, and infant affect and attachment. Infant Mental Health Journal. Special Issue: Defining the caregiving system, 17(3), 257-275.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), Growing points in attachment theory and research. *Monographs of the society for research in child development*, 50, 66-104.

Main, M. & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. Greenberg, D. Cicchetti, N. Cummings (Eds.) *Attachment in the preschool years: Theory, research and intervention* (pp. 121-160). Chicago: University of Chicago Press.

McCullough Vaillant, L. (1997). *Changing Character: Short-Term Anxiety Regulating Psychotherapy for Restructuring Defenses, Affects and Attachment.* New York: Basic Books.

Moreno, J.L., Fox J. (1997). *The Essential Moreno: Writings in psychodrama group method and spontaneity.* New York: Springer.

Nijenhuis, E., van der Hart, O., & Steele, K. Trauma-related structural dissociation of the personality. Trauma Information Pages website, January 2004. Web URL: http://www.trauma-pages.com/nijenhuis-2004.htm.

Ogawa, J.R., Sroufe, L.A., Weinfeld, N.S., Carlson, E.A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomotology in a non-clinical sample. *Development and Psychopathology*, 9, 855-879.

Orlinsky, D. E. & Grawe, K. & Parks, B. K. (1994). Process and outcome in psychotherapy. In: S. L. Garfield & A. E. Bergin (Eds.). *Handbook of Psychotherapy and Behavior Change (4th ed.)*. (pp. 270-376). New York: John Wiley & Sons.

Paulsen, S. (1995). EMDR: Its cautious use in the dissociative disorders. Dissociation, 81, 32-41.

Perls, F. S., Hefferline, R., and Goodman, P. (1951). *Gestalt Therapy.* New York: Dell.

Putnam, F.W. (1997). *Dissociation in children and adolescents: A developmental perspective.* New York: Guilford Press.

Schore, A. (1994). *Affect regulation and the origin of self: The neurobiology of emotional development.* Mahwah, NJ: Lawrence Erlbaum Associates.

Schore, A. N. (2002). Advances in neuropsychoanalysis, attachment theory, and trauma research: Implications for self psychology. *Psychoanalytic Inquiry, 22* (3), 433-484.

Schwartz, R. (1995). *Internal family systems therapy.* New York: Guilford Press.

Siegel, D. (1999). *The Developing Mind: Toward a Neurobiology of Interpersonal Experience.* New York: Guilford Press.

Stern, D.N. (1995). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology.* New York: Basic Books.

Stiver, I. P. & Miller, J. B. (1995). A relational perspective on what is healing in therapy. In: B. S. Mark & J. A. Incorvaia (Eds). *The Handbook of Infant, Child, and Adolescent Psychotherapy: A Guide to Diagnosis and Treatment* (pp. 357-373). Lanham, MD: Jason Arson, Inc.

Trevarthen, C. (1990). Growth and education of the hemispheres. In C. Trevarthen (Ed.), *Brain circuits and functions of the mind: Essays in honor of Roger W. Sperry* (pp. 334-363). New York: Cambridge University Press.

Trevarthen, C. (1993). The function of emotions in early infant communication and development. In J. Nadel & L. Camaioni, eds., *New Perspectives in early communicative development* (pp.48-81). New York: Cambridge University Press.

Tronick, E.Z. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health J., 19*(3):290-299.

Tronick, E. Z. (2003). "Of course all relationships are unique": How co-creative processes generate unique mother-infant and patient-therapist relationships and change other relationships. *Psychoanalytic Inquiry, 23*:473-491.

Watkins, J.G. & Watkins, H.H. (1997). *Ego states: Theory and Therapy.* New York: W.W. Norton.

Winnicott, D. W. (1965). *The maturational process and the facilitating environment.* New York: International Universities Press.

Diagram I: Intra-relational Triangle

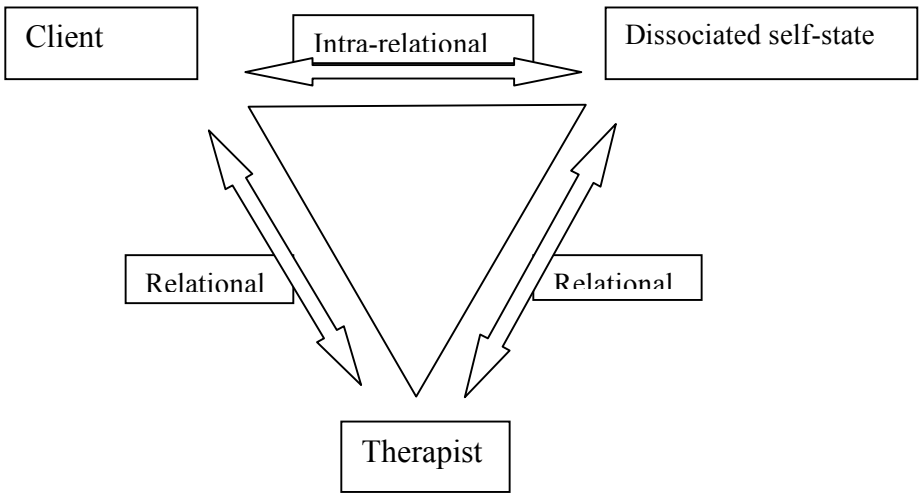

Diagram II: AEDP Three States and Two State Transformations (Fosha, 2002)