

Editor's Commentary on Ton Coffeng

Morton Prince (1906), the American psychiatrist who pioneered the clinical concept of dissociation, observed similarities between psychosis and dissociation. Ton Coffeng describes similarities between the treatment of psychosis (Pre-Therapy pre-symbolic processing) and the therapy of dissociation.

Coffeng has successfully expanded the whole concept and application of Pre-Therapy to dissociation. First, as in the treatment of psychosis, he applies Pre-Therapy as a first stage in treatment. Two reasons for this are that dissociated clients often do not have access to their experiencing, and secondly, they often cannot articulate their experience and are pre-expressive. Coffeng explains that both access to experiencing and articulation of experience are goals of Pre-Therapy. Then he applies pre-symbolic processing, which was originally used for hallucinatory images, to flashback imagery. Coffeng also demonstrates the pre-experiential property of the contact reflections as they precede experiential focusing (Gendlin, 1996). Coffeng has successfully expanded the clinical range of Pre-Therapy/pre-symbolic methods as first steps in the treatment of dissociation, to be followed by more traditional experiential/client-centered work.

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CHAPTER 8

The Therapy of Dissociation: Its phases and problems

TON COFFENG

Therapists working with dissociated and traumatized clients commit themselves to a long project. The therapy of these clients is long and intensive. Its beginning is difficult, when clients, being used to isolation, have to share their inner life. Therapists understand the client's problem with talking and are happy with what can be said. They accept crises, extra sessions or phone calls, since their clients have no other ways of coping. When trust and attachment develop, clients begin to communicate more, and the exchange becomes easier. On this basis, the trauma can be addressed properly. After some time clients begin to integrate their trauma, and dissociative symptoms and flashbacks decrease.

In this latter stage, however, incidents may occur that disturb the ongoing process. Clients function as they did in a previous stage. They dissociate again, having been integrated already. They don't express themselves as they did, or become mute. Some clients become demanding or reluctant to proceed. The therapy is stranded. Therapists are surprised, as they didn't expect problems at this stage. They are confused also, not being able to talk with the client as before. They try interventions from an earlier stage, but discover that these do not work. They become discouraged, seeing their client deteriorating. These incidents need a more directive approach, so that their background can be explored. When this problem is solved, the therapy can resume its course. The incidents have to be placed in a context, as part of the extended therapy of dissociation. Therefore we start with a description of the therapy. In this case, it is a client-centered/experiential therapy, with two experientially different phases. However, the sequence of the article is not intended to suggest that the late incidents are specific to the therapy model presented here. They seem to occur to other therapists also, independent of their approach or style.

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THE PHASIC CHARACTER OF THERAPY

According to the official 'state of the art,' the therapy of dissociation has three phases: (1) stabilization and symptom reduction; (2) treatment of traumatic memories; and (3) reintegration and rehabilitation (van der Hart, van der Kolk & Boon, 1998). These phases are planned and have a protocol of what a therapist does in each phase. Roy (1991) introduced a different and client-centered approach, in which the client's process was followed rather than directed. Inspired by her, I developed a therapy that included various elements (Coffeng, 1996). These elements appeared to have their own time in the therapy. Watching the processes of clients during the course of therapy, I could distinguish two experientially different phases, each having its own pace and language (Coffeng, 2002a, 2002b).

FIRST PHASE

In the beginning of therapy, clients have frequent dissociative switches, which interrupt their memory and consciousness. They lose track of the day. Some clients have a Dissociative Identity Disorder (DID), a severe form of dissociation (Ross, 1997). They have different identities, alter-personalities or 'alters' inside, with different names, ages, characters, each carrying a part of the trauma memory. The multiplicity leads to internal discussion, conflict, chaos and the hearing of voices. Alters take their turn to control the clients' behavior; clients have only partial control over this.

In addition, clients have traumatic flashbacks, which disturb their consciousness as well. During a flashback victims re-experience their trauma as if it is happening again, being unaware of the present. At those moments, clients cannot talk about it (van der Kolk, 1996). Moreover, as their traumatic memory is affected by dissociation, victims have fragmented flashbacks, which they don't recognize as parts of their trauma (Braun, 1986).

The functioning of dissociative clients at this stage reminded me of Prouty's psychotic clients (Prouty, 1994). He found them *pre-experiential*: they don't have access to feelings yet. Their process is basic, slow, and repetitive, being a stage before the experiencing of neurotic clients. They are also *pre-expressive*: they cannot express their experience yet. Prouty attributed these difficulties to a lack of *psychological contact*. Psychological contact is the ability to have contact with reality, with one's feelings, and to communicate with others. Prouty developed a method to restore contact, called *Pre-Therapy*. It consists of specific *contact reflections*, of which there are five types. (Situational reflections describe the environment and support contact with reality; body reflections describe the body posture of the client and assist contact with one's body, oneself and with reality; facial reflections describe what can be

seen on the client's face and support contact with feelings; word-for-word reflections duplicate exactly what the clients say, and support their communicative contact; and reiterative reflections repeat reflections which had an effect before, and reinforce the process.) These reflections are simple, slow and repetitive, and they fit with the slow and repetitive process of psychotic clients. They are based on Rogers' conditions, but adapted to their language. Reflections need time and have to be repeated, before any effect can be seen. Results were reported in pilot studies, clinical vignettes and videos (a complete list of references can be obtained from the author). Most clients improved in contact. Some could have psychotherapy afterwards; others could discuss their psychotic experience. Pre-Therapy has been implemented in several clinical settings (Prouty, Van Werde & Pörtner, 2002).

I noticed similarities with dissociative clients. Their initial process is also pre-experiential. It is slow and repetitive, although it seems hectic sometimes from the outside. When re-experiencing their trauma during a flashback, clients cannot discuss or process it: they are pre-expressive. Dissociative switches and flashbacks disturb their psychological contact. Therefore, I characterized the first phase of therapy as *pre-experiential*. I followed clients with slow, repetitive and literal reflections, calling these the therapeutic language of the first phase. Contact reflections belong to this phase also. They support the clients' impaired contact during switches and flashbacks, giving them a foundation. I assumed that clients wouldn't need to dissociate so much when this foundation was stronger. It should enable them afterwards to address their trauma.

Prouty's phenomenological approach to hallucinations is also important. He observed that these had a process, which he called *pre-symbolic*. His therapy, *pre-symbolic processing*, has four stages with stage-specific reflections. Initially, the shape of hallucinatory images changed, when they were reflected literally. In the second stage, clients perceived affect in their hallucinatory image, and both affect and images were reflected. In the third stage, clients noticed affect in themselves instead of outside, which was reflected also. Another shift followed, when the hallucinatory image changed into a flashback of a past (traumatic) event. Clients were shocked when they realized they had had that experience themselves. They needed to integrate it, which occurred afterwards in a typical experiential therapy, that being the fourth and final stage. This procedure has been illustrated with clinical vignettes (Prouty, 1994, 2004).

A similar process can be observed in dissociated clients, when their traumatic flashbacks are reflected literally, without going into their content. It is trusted that the traumatic story will explain itself in due time, like the hallucinations of Prouty's clients did. Gradually, memory fragments come together and they become a complete memory of the trauma, which

corresponds to the third stage of the pre-symbolic process. Slow reflections help to pace the emotional turmoil when this complete flashback occurs.

The clients' distinct dissociative states are reflected literally as well, and not explored. More precisely, they are reflected phenomenologically. It is expected that these personalities will explain themselves afterwards. Therefore, the first phase of therapy is characterized as *pre-symbolic*. *Pre-symbolic processing* fits into this stage, being its corresponding therapeutic language.

Summarizing, the process of the first phase is pre-experiential and pre-symbolic. The therapeutic language consists of contact reflections (Pre-Therapy) and pre-symbolic processing. Contact reflections support the process in general, while pre-symbolic processing is attuned specifically to the content of the process.

CRITICAL EPISODE

At the end of the first phase, clients improve in various aspects. Owing to contact reflections, they have more contact with reality, with others and with themselves. There is trust in the therapist, who has passed tests of reliability. The relationship is stronger. Having more contact, clients don't need to dissociate so much. Dissociative barriers between alter-personalities become permeable, and these alters can't ignore each other any longer. With the decreasing dissociation comes an improvement of memory. Flashbacks, being parts of their traumatic memory, come together. When their memory of the trauma becomes complete, it is still a frightening flashback. Clients are shocked to realize that they experienced that trauma themselves. They cannot escape or dissociate as they did before, and have to face it. But they cannot cope with the intense emotions of it either. They begin to notice feelings, but don't know yet how to deal with them. They are unfamiliar with feeling experientially. They are not used to expressing feelings in symbolic language. In short, they are in no-man's land. This episode corresponds with the third stage of Prouty's pre-symbolic process. I called it 'critical', as it requires the strong presence of the therapist. This necessity is not recognized often, as therapists assume that their client won't need help at this stage. They may go on holiday without arranging for a back-up or replacement. In this stage of therapy, it is particularly important that therapists are available or that they arrange a solid replacement. Support, extra sessions or phone calls are needed, sometimes even a short admission. Clients should be informed about the critical episode and possible facilities. *Clearing a space* (CAS), the first step of focusing (Gendlin, 1996), is a valuable supportive technique at this moment. An emotional distance is created between the client and the traumatic experience. McGuire (1984) added imagery to CAS for distressed clients. She asked if they ever had a positive experience, and encouraged them to

imagine as if they were at that place. The positive image helps them to feel space and to recover, while the traumatic experience is placed at the edge of the positive image. CAS has the effect of pacing, so that the working on the trauma can be postponed.

Usually, the shift from the first to the second phase is rapid, making the critical episode short. Sometimes, the change is gradual, leading to a distinct intermediate phase, resembling 'the grey zone' of Van Werde (2002). In that case, it has features of both first and second phases, and so reflections of the first phase have to be alternated with those of the second.

SECOND PHASE

In the second phase of therapy, the process shifts from pre-experiential to experiential. Clients get contact with feelings and are more curious than afraid of them. They want to learn focusing (Gendlin, 1996). The need to dissociate decreases. In fact, clients find switching more disturbing than helpful: they begin to integrate. Having more contact with reality, they are less afraid of flashbacks, realizing that these come from the past. As their amnesia decreases, they remember more and want to remember more. The memory of the traumatic event becomes complete, being still a flashback. Clients face their trauma, and have to integrate it. Instead of being in the trauma, they learn to look at it, knowing it is in the past. The traumatic memory has to become a narrative memory. The shift, from re-experiencing the trauma to feeling it experientially, is accompanied by strong emotions. Clients fear they will explode or lose their boundaries, if they feel what really happened to them. For such critical moments, Pessó (1988) offers a psychomotor technique of 'holding and containment.' Group members, acting as supporting figures, hold the client, saying that they will protect her from exploding and that they are assisting her to endure strong feelings. They protect the ego-skin of the client, forming an 'ego-wrapping.' When supported in this way, clients are able to contact their feelings, without the fear of getting lost.

These supportive figures however, are absent in individual therapy. Instead, their help can be asked for in the form of an image, but this is often not sufficient. Verbal support or the contact reflections of the therapist also fail. The client needs physical support. So the therapist takes the role of a supportive figure. Physical contact by therapists, however, is controversial, especially in circles of traditional therapy. But body techniques can be offered safely and professionally as long as preconditions are observed (Bohun, Ahern & Kiely, 1990; Durana, 1998; Hunter & Struwe, 1998; Stenzel & Rupert, 2004). The body support and the stronger therapeutic relationship provide a context in which the working through of the trauma can take place (Coffeng, 2002b). This process resembles the process of grief.

Three emotional themes are apparent in the second phase. At first clients experience anxiety, being shocked about what happened; in a later stage, they feel pain, realizing how it has hurt them emotionally and physically; and finally they feel sadness, when they see what they have lost.

Focusing is relieving. When clients are assisted in staying with an anxiety-provoking problem *and* in attending to their felt sense of it, they feel a relief. There is also a change: the problem feels different afterwards (Gendlin, 1996). The trauma can be digested with small, experiential change steps (Gendlin, 1990). Clients focus on the vague felt sense, which contains all aspects of their traumatic experience. It is felt that it happened. Clients are reassured when they learn that the flashback was a remnant of a past event, and not a sign of madness. Their body knew it. When clients have contact with their body, they have access to the body's healing capacity. Their felt sense can be consulted to repair or reconstruct the traumatic experience. Their body has a 'blueprint' (Gendlin, 1993), or an inner knowing about what should have happened, and what should not have happened. It knows that children should not be raped, and that lies should not be believed. The body is the center of truth (Pesso, 1990). Because of brainwashing, the mind of victims is mixed up with false moral rules (Spiegel, 1986). The therapist assists in restoring their blueprint by mentioning proper rules. Clients check with their felt sense whether these rules fit.

The process has changed also from pre-symbolic into symbolic. Clients use symbolic language to express feelings and so the therapeutic language becomes symbolic. Images are helpful to express feelings. These contain more aspects of the felt sense than words (Gendlin, 1996). Words, having limited meanings, may also evoke self-criticism, especially with victims. Images give more emotional space, which appeared helpful for grieving clients (Coffeng, 1992). Trauma clients can use imagery when they ask their blueprint: 'What should have happened?' They can imagine ideal caregivers. Therapists assist with their imagination. A court can be imagined, where justice is done. Trauma clients like imagery; they have symbolic energy, bringing drawings, paintings, etc. that have a symbolic meaning.

INCIDENTS IN THE SECOND PHASE

Since the language of the second phase has become experiential and symbolic, the interaction with the therapist becomes quick and flexible. There are fewer misunderstandings. The work on the trauma is intensive, but it gives a change and relief. The relationship being steady, therapists relax and enjoy the improvement. They look forward to seeing the end of therapy, having had a

long journey with the client. In any case, they don't expect problems. They are surprised when incidents happen that contradict what they supposed. Some clients slip back into pre-experiential functioning and start to dissociate again. I was confused when this happened to me: the same client, who was integrated before, now seemed far away and did not respond to symbolic language. My second reaction was doubt: had I been too optimistic? Had we not reached the second phase? I tried to be patient again and returned to the slow speed and to the contact reflections of the first phase. This appeared to be unproductive. Clients continued to dissociate. Their alters complained and had many wishes to be fulfilled, as if time was endless. My third reaction was despair. It was as if nothing had been done. The end of therapy seemed far away. My fourth reaction was anger. I confronted the clients with their complaints, the limits of my age, and the waste of time. I became impatient and practical. To my surprise, it worked. Clients appeared able to work hard, to grieve and even to discuss the end of therapy. Sessions could be hectic, but clients could understand and integrate what happened. I shall describe the different backgrounds with vignettes. There are exceptions, where more patience and empathy are needed. Examples of these are given as well.

HIDDEN ALTER

A client had already had nine years of therapy when I replaced her therapist, who had become ill and could no longer continue with her. The client had a Dissociative Identity Disorder from early traumas, and she also had a physical handicap. She arrived with the smile of a happy patient. As the weeks passed, the smile changed into a depressed and annoyed look. She would sink into her chair with a deep sigh, complaining about her physical disease. She visited academic hospitals to get a second opinion and to hear about new medical developments. She also consulted experts on heredity and fertility. Each time she told how disappointing these visits were. Hearing this week after week, I became exhausted. I asked how long she was going to continue this medical journey before we could start therapy. I said that I feared I would be retired before that moment. I also said that I had difficulty with her annoyed look, which suggested she did not expect help from me either. It discouraged my optimism. The client seemed embarrassed, but she admitted I was right. She had stuck to her patient role, believing it was the only way to get attention from her family and from me. She feared I wouldn't like her when she showed her real self. Our contact improved, but she remained depressed and skeptical about therapy. I was not convinced that the air was clear. Remembering Kluft (1986), I inquired if there was another dissociated part of her who I didn't know, and who was responsible for this mood. She was irritated, as if this question was not allowed, but then the unknown alter appeared. He did not

trust people, and expected I would fail like other people and send them away. He was waiting until I was finished; then, he would carry out his plan to commit suicide. He was depressed, and I asked the reasons for his depression. He explained it was because he carried the blame of past events. I could understand him and he felt himself being taken seriously. I asked if he could let me know when his death wish was strong, before he killed himself and the other alters. He did not expect I would be available at such moments. I told him my possibilities and limits, and we made a deal for emergency calls. However, I confronted this alter with another problem: we could not proceed with therapy if he would not give us a chance. He gave me the benefit of the doubt. After that, the therapy went well. More incidents followed, but the personal confrontation and direct response cleared the air. The client dared even to announce the end of therapy by herself. We ended nicely after half a year.

Kluft (1986) discovered 'new' alter-personalities when he confronted dissociative clients with their unproductive behavior during the last part of therapy. These alters had been hidden and frustrated change. Kluft negotiated with these alters until they agreed to cooperate. From that moment, therapy went well. Kluft's discovery is helpful when the therapy becomes chronic. It is also important to know the hidden alter, as this personality may have crucial information: a missing part of the traumatic memory, or the knowledge about dynamics between alters.

LAYERING OF MEMORIES

The appearance of new traumatic memories can be shocking for therapists who supposed they knew the entire story. These new memories usually come after an incident. I was confronted by this years ago. A client underwent a traumatic narco-analysis when an adolescent. She remembered the psychiatrist carrying a tape recorder while he brought her to the basement of the hospital. When she awakened again, she was afraid that she might have disclosed things she hadn't wanted to disclose. The doctor gave her electro-shocks afterwards, supposedly 'to forget the incest story.' She disliked this authoritarian doctor, as he had made erotic insinuations to her. Years later, another memory emerged. My co-therapist saw the client during my absence. At that time, the client accompanied somebody to hospital: the same hospital where she had had the narco-analysis. While her relative was examined, she went downstairs to find the narco-analysis room. There, the flashback of the original story returned. By carrying a tape recorder, the psychiatrist had *pretended* narco-analysis, but in the room he had forced sex on her. When she resisted, he had injected drugs, had fastened her on a stretcher and had raped her. Afterwards, he had told her that nobody would ever believe her. Shocked and confused, she had run away. She was fetched by nurses and

punished by the doctor. He gave her electro shocks so she would forget *this* event! The client was shocked when she realized what had happened. She also felt reassured that the original memory had come back, and that my co-therapist believed her. She blamed me for having believed the first story of the 'narco-analysis'. The original memory had not come to the surface earlier, as she had expected that I would not believe her, as the abusive doctor had predicted.

The layering of traumatic memories has been observed in victims of the holocaust (van Ravesteijn, 1978), and in those of sexual abuse (Brown & Fromm, 1986; Terr, 1994). The memory of the original trauma is concealed under cover or screen memories. The cover memory is supposed to be a defense against the fear of being not believed, or against feelings of shame about the trauma. Another cause of the layering of memories is the connection of repeated traumatic experience with the emotional development of children (Coffeng, 1992). It becomes linked with it while it interferes with it as well. Attachment is affected also (Schore, 2003; Sinason, 2002). Because of these mechanisms, trauma memories don't come back as a story, but in the shape of problematic interaction or transference (Brown, 1997). This phenomenon resembles the reappearance of the trauma story in the re-enactment of children: 'behavioral memory' (Terr, 1994). The trauma is visible in their play, while the children are amnesic about the story and unable to tell it.

Dissociation contributes to the layering of traumatic memory, as trauma experience goes together with 'peritraumatic dissociation' (Marmar, Weiss & Metzler, 1998). It causes a split between the 'Emotional Person', who carries the traumatic memory, and the 'Apparently Normal Person', who is amnesic about the trauma (Nijenhuis, van der Hart & Steele, 2001). These mechanisms account for the various expressions of traumatic memory. Some victims have alternating flashbacks and amnesia, while others recover their memory after a long amnesic period (Harvey and Herman, 1996). Clients with a Dissociative Identity Disorder have alters who carry a trauma fragment, separated by dissociative barriers from other alters who don't know. The split between alters can be on different levels of experience, knowledge and sensation: some alters know the content of the story, while others carry feelings of the trauma, or images (Braun, 1986). When therapists attend to incidents, these alters may appear with their part of the story.

Due to the layering of memory, the original story appears late in therapy. Therapists don't expect to hear a new version of the traumatic story. Having been amnesic about this part of the memory, clients are shocked as well. The example given shows that one should not assume that one knows the whole story from the first telling. The client's behavior, the interaction, or countertransference feelings can give a cue of traumatic memories not yet revealed.

'THE UNSPEAKABLE'—THE EFFECT OF TRAUMA ON LANGUAGE

The term 'pre-expressive' has been used for the language of psychotic patients (Prouty, 1998). Their words are concrete and hard to understand. Later in therapy, when more words are added, the earlier words make sense. They appear to have announced a crucial message and to have implied experience. Dissociative clients are pre-expressive in the same sense. Having flashbacks and switches, they use telegram words. Unable to feel the whole complexity of their trauma, they cannot describe it in semantic language. Clients become expressive in the second phase. They use experiential language. Previous and pre-expressive words come back, but now together with their explanation. Their words cover different aspects of experience and no longer just concrete things.

There are exceptions. A client grew up with a chronic psychotic father, who depended on her and who abused her sexually. Her mother denied the problems; she would run away when the father's psychosis was critical, leaving the client alone with him. The client dissociated, behaving as if she could manage and ignoring her own anxiety. She was confronted with confusing ideas and double binds (Spiegel, 1986). Her father told her he would come back after his death to collect her, so the client anticipated his return when he finally committed suicide. Having been blamed by her mother for having made her father psychotic, the client believed she could make other people ill, and she closed her eyes whenever people passed.

When she came to therapy, she hardly spoke. She had frequent dissociative switches which prevented her from continuing a sentence or answering a question. It was as if she had to cross a busy highway before she could speak again. Her language was poor: she spoke in few words which could mean many things.

When we reached the second phase of therapy, her speech remained simple. I needed to teach her to use more words. When her language became richer finally, there was another surprise. She became mute again. After an incident, she explained the silence. It had to do with what had happened seven years before, when her brother had killed himself. I had supported her at that time and assisted her with grieving; but I had not realized the impact of the loss. It had been like a bomb, and had destroyed her language. It had triggered memories of the previous suicide of her father. The loss was also catastrophic, because her brother was the only witness of her traumatic childhood. She was left as the only one who knew the story. Losing him, she lost the hope of telling it to other people, fearing they would not believe her. Hence, she lost the perspective to escape from her dissociative isolation. She was without words again. I had to stay with 'the unspeakable,' her existential inability to speak.

The unspeakable is an important aspect of traumatic experience. It is related to *alexithymia*, a term introduced for psychosomatic patients. It is the inability to have contact with feelings and to express them. Alexithymia has been used also for trauma victims (Hyer, Woods & Boudewyns, 1991). The crash of the trauma makes it impossible for victims to address their feelings and to share them: it is too much. There are no words to describe the intensity and complexity of the trauma, in which fantasy and reality have been mixed up (Laub & Auerhahn, 1993). Victims of concentration camps used psychological defenses to survive in the middle of repeated trauma and danger (Bluhm, 1999). These mechanisms are difficult to change afterwards. It is hard to contact their feelings and to integrate the trauma. La Mothe (2001) described 'Freud's Unfortunates': clients who are well adapted and who remember all details of the holocaust. When they talk about it, it is in a detached way. On the other hand, they have traumatic nightmares and flashbacks that do not change and that they cannot discuss. The catastrophic knowledge of the trauma is unexperienced experience that paradoxically stands for an indescribable core of an event that undermines the self in relation and the concomitant capacities for language, narrative and knowledge. Laub and Auerhahn (1993) connect language—the capacity to symbolize—with the presence of an internalized, empathic other person. The more the victim is in the middle of horror, the more the empathic other person is felt to be absent, and the more language becomes impossible. The victim is kept in traumatic images and nightmares, unable to put these experiences into words. There is a gradation in the severity of traumatization and loss of language. The more a person has a distance from the trauma, the more language and fantasy are preserved. Children of holocaust survivors are more remote from the trauma than their parents, but still too near to be able to talk about it. At the end of the spectrum are people who were not involved. Their language and fantasy are intact. They have access to their feelings: they can imagine the trauma and empathize with the victim. The empathy involved in the therapy situation, however, makes these listeners (therapists) vulnerable at the same time (Wilson & Lindy, 1994).

Another cause of the unspeakable is the strange experience of victims returning from the traumatic environment to the safe world (Cyrulnik, 2002). It is as though they come from another planet. They cannot feel 'normal' again in the normal world. There is still the other reality of the traumatic experience. If they had a safe childhood, it is difficult to reconnect with that time. There is a gap. Arriving in a safe world, they remember the unsafe world. When they try to make language about it, this language seems not applicable to the safe world and may not be understood there either.

The unspeakable can happen during the second phase of therapy. Thus, clients who make progress on all aspects of therapy may remain without words at crucial moments. The human presence of the therapist is essential then. One tries to stay with what cannot be told.

PSYCHOSIS?

A client was integrating from a Dissociative Identity Disorder, and she reached the end of a long therapy. Suddenly, she asked me to send her to hospital. I was surprised, because she seemed to be doing well. I hesitated also because she had had a bad hospital experience previously. But she insisted, fearing a violent alter-personality would take over. Moreover, she was afraid of becoming psychotic; she had had a psychosis ten years ago. I offered extra sessions and phone calls, ready to arrange admission any moment. Before I could see her again, however, she had already been admitted. She was said to be psychotic with hallucinations and delusions. I couldn't believe it. She recovered quickly and we resumed therapy. But her fears of becoming psychotic remained. I challenged her to address 'the psychosis' and to find out what it was about. She would choose an image that symbolized it and focus on that image. She had a drawing of her first psychosis that she had made previously. She imagined the drawing in front of her and focused on it. After a silence, she burst into laughter, exclaiming: 'That I have been always afraid of that!' She had believed she had a psychotic core, because her father had told her so. By telling her she was crazy, he had tried to justify his sexual abuse. Now, she could see through his false accusation and she was relieved to be rid of that burden. Afterwards, the reasons for her two 'psychotic attacks' also became clear. After this clarification, she relaxed completely and she could end her therapy without fears.

I had assumed that dissociative clients could not become psychotic, having been told that dissociation would exclude a psychosis, dissociation being a coping strategy to prevent it. However, dissociative psychoses do exist (van der Hart, Witzum & Friedman, 1993). The border between dissociation and psychosis doesn't seem sharp. Another example came recently from Prouty (2004), who reviewed a therapy together with the client. At that time, she had hallucinated a python. Looking back however, she realized she had had more hallucinations than that of the python alone. Somebody made a picture of all the hallucinations. The picture resembled the constellation of alters of a DID client!

DISCUSSION

It is hard to find reports of incidents late in therapy with dissociative clients. Sakheim, Hess and Chivas (1988), who mentioned crisis episodes in the course of therapy, did not foresee problems in the last part of therapy. Chu (1988, 1994) discussed various difficulties, which do not seem to be related to the end phase either. The question could arise of whether the late problems are a consequence of my therapy model. This is unlikely as I heard of similar problems from therapists who use other approaches. It is also unlikely since these incidents have different causes and do not occur with every dissociative client.

The examples given are typical for clients who experience trauma and dissociation. They differ from problems late in any therapy. Regression is a common phenomenon, when clients fall back into a rigid functioning. It is due to their stress of integrating new experiences and changing old concepts. Fearing that they may lose control, they try to control their process. They lose contact with their bodily experience and become 'structure-bound' (Coffeng, 1991). With an adequate therapist response, however, clients regain their flexibility quickly.

Negative therapeutic reaction, a standstill near the end of therapy, is another problem (Hahn, 2004). Clients expect to be devalued by the therapist if they become really known. They re-experience the shame which they felt during the early affective misattunement from their former caregivers. The shame prevents them from showing their autonomy and from moving forward. Trauma victims have also feelings of shame that may prevent change (van Ravensteijn, 1978). It is a different shame, however, coming from their humiliation during the trauma.

Since the late incidents may contain different and crucial information, it is important to address them. Therapists must notice them, confront their client with them, and explore the background together with the client. This requires alertness, energetic action and curiosity. Some therapists are too tired at the end of a long therapy, and not ready for new problems. They miss incidents or become bored. This can be a reason to consider a replacement therapist, a colleague who can deal with the incident with fresh energy. The new therapist can move freely, not being fixed in the patterns of the previous relationship. He or she can afford to confront and to be ignorant of existing patterns of interaction.

I have felt the freedom when I have replaced colleagues, as shown in the first vignette. I had a similar experience when I assisted a colleague. She was tired from a long therapy that did not seem to be moving. I joined her in the sessions, focused on other things than the ones they were using, and suggested

new options. The colleague regained her energy, and the therapy started moving again. I felt the difference also of being the first therapist. Exasperated after a long therapy, I announced the end of it. To my surprise, my flexibility returned. It felt as if I had stepped out of our old relationship. Interventions became easier, and we could end therapy. Another surprise was that I became open again to the comments of colleagues. I had not heard them before, being locked up in the old relationship.

There is another reason to consider replacement. Many therapists stop working with trauma clients after some time (Sussman, 1995). They are disillusioned, or burn out. Vicarious traumatization is one cause (Wilson & Lindy, 1994). Another might be that they were stuck in an interaction pattern with the client. It is difficult to escape from this pattern, despite supervision. Thus, the rule that the same therapist should do such a long and intensive therapy alone needs to be questioned. When replacement is possible, therapists can stop in time, instead of being 'condemned' to the same client. They can preserve their energy and optimism.

It is hard to find therapists for dissociative clients, or to find a replacement therapist, especially when the first had problems. This difficulty adds to the isolation of trauma therapists. It is better to organize replacement in a network. This is a supervision group in which participants are co-therapists for one another and they know one another's clients. Co-therapists replace the therapist during holidays or illness, and they can assist in sessions. Co-therapists should be ready also to replace a therapist completely. When they offer to take over, the first therapists feel really supported and they 'get some air'. When recovered, they are ready also to replace a colleague. It is a mutual commitment. This spirit reminded me of some of my previous supervisors. They came to meet with me in person during night duties, instead of advising by telephone only.

Dealing with late incidents is a difficult enterprise, but it is also interesting. The difficulty lies in the combination of being energetic and sensitive at the same time. Expressions of the client should not be taken for granted but need to be questioned again and again. It is not a matter of believing but of exploring, as previous expressions of the client may have a new meaning. A balance has to be found between patience and curiosity. This balance resembles what McCann and Coletti (1994) called 'the dance of empathy.' In their wish to understand, they circle around a client with questions. Responses of the client help them to learn more and to empathize. From there they ask the client new questions, in order to understand better. It begins with a circular dance with the client, but over time it becomes a spiral movement as the therapist comes nearer to the client. The combination of curiosity and checking—recommended by the authors as a way to prevent empathic strain—is also an excellent way to deal with the late incidents.

The concept of two phases can help therapists to find the language that corresponds to their client's process. This concept should not be used as a rigid model, but as a rough one with space for exceptions. This implies curiosity and flexibility during the whole course of therapy. Alertness is required, especially at the end. Sometimes therapists need assistance, or replacement, to maintain their curiosity. Without help, their therapy becomes a burden. With proper arrangements, it can remain a challenge.

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