Two Phases of Dissociation, Two Languages

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Abstract. From a person-centered/experiential perspective, the therapy of dissociating clients seems to have two phases: a pre-experiential and an experiential phase. Initially clients process traumatic feelings in a pre-experiential and pre-symbolic way. Their process is slow. Their trauma cannot yet be told. The therapeutic language of 'Pre-Therapy' and 'Pre-Symbolic Process' (Prouty, 1994) fits this phase. The approach uses slow, literal and descriptive reflections. It assists clients to recontact reality and their affect, and it facilitates their communication. Consequently their inner process is supported. As this develops gradually into an experiential and symbolic process, they enter the second phase. The trauma is no longer experienced as fragments but as a whole. It can be expressed with symbolic language, and become integrated. The two phases were illustrated with video-clips taken from actual sessions. A third video showed the shift from the first to the second phase.

1. INTRODUCTION

Clients who were traumatized in childhood often have dissociative symptoms (Marmar, Weiss and Metzler, 1998). Some have a 'Dissociative Identity Disorder' (DID, formerly Multiple Personality Disorder): a severe form of dissociation in which their identity is split into several 'personalities' (identities, alters), with different age, character, memory and behaviour (Ross, 1997). These personalities, separated by dissociative barriers, are not aware of each other. One of them comes to the foreground during a switch in consciousness. Clients have no control over this. They are handicapped, as awareness of time and continuity is disrupted; they lose track of time, forget appointments, and don't remember where they have been; they have amnesia for recent and past events; and concentration and daily tasks consume much energy and time. These clients suffer also from a Post Traumatic Stress Disorder (PTSD), with flashbacks of the trauma, and alternating episodes of stress and numbness. Their memory of trauma is fragmented: they re-experience a part without remembering the whole. It makes them unsure about the traumatic origin of their suffering.

Traumatization is complex and multilayered (Herman, 1992; v. Ravesteyn, 1978). It influences the development of children, leaving scars on their personality (Coffeng, 1996a). It requires therapy of the whole person (Adshead, 2000). The officially accepted treatment of dissociation, which used to be directive and focused on symptoms, has become open to other orientations recently, introducing concepts such as transference and attachment (Steele, 1995). I missed, however, a client-centered approach: clients should be asked what they need. As survivors, they can show the way to therapists. I also looked for a process-oriented approach, which respects dissociation and other symptoms as ways to cope with trauma and intrusive memory. Prouty (1976, 1977, 1981) showed such respect. He has a trust in the process of clients, whether psychotic or not. His approach is process-oriented and phenomenological.

This facilitates a development in which psychotic material can change. Hallucinations changed and began to explain themselves: they appeared to refer to previous trauma! Fascinated by this work, I realized that dissociative clients had a similar process and that Prouty's approach would fit them, so I adapted it for traumatized borderline and dissociating clients (Coffeng, 1994, 1995, 1996a, 1996b, 1997, 1998, 1999, 2000a and b). Looking at their therapy, I observed that it had two phases, each with a typical tune and pace. Each phase needs a specific therapeutic language. I call the first phase 'pre-experiential and presymbolic', the second: 'experiential and symbolic'.It seems crucial to recognize this biphasic pattern. It helps to find the tune and pace of the client. The phases will be discussed below. A separate paragraph will be spent on the shift from the first to the second phase: a critical episode, in which many things change in short time.

2. PHASE I

A. Pre-experiential process: a slow process

Initially, the memory of dissociative clients is 'traumatic': they have flashbacks as if the trauma is recurring. It's different from 'narrative' memory, when one remembers an event and realizes it is about the past (v. d. Kolk, 1996). Their trauma memory is also split by dissociation into fragments and amnesic gaps. Clients suffer but cannot relate to their feelings or express them in understandable language. They have alexithymia: the suffering has no words (Hyer, Woods and Boudewyns, 1991). They fail to communicate their trauma or to work it through and they become retraumatized if asked to do so. On the other hand, they wish to share their trauma and to get rid of it. It is not just their trauma memory that is affected by dissociation, but also their whole experiencing. Due to switches in consciousness, they lose track in therapy. Sentences are interrupted by voices in their head and clients lose what they said before. It takes effort and time to keep their track and to retrieve what they wanted to say. It is a slow process needing a slow approach. In addition, clients are not at ease, as they had no safe relationships before.

Therapists, confronted with the changing appearance of the client, don't feel at ease either. I characterize this phase as 'pre-experiential'. The term was given to the process of psychotic clients by Prouty (1976). '*Pre*-experiential' means that it precedes experiential process. It is different: it is a slow and repetitive process. It was missed by researchers, who thought psychotic clients were not experiencing (Rogers, 1967). These clients are 'pre-expressive' (Prouty, 1998): their expressions are concrete and not yet symbolic. Prouty developed ways to support and facilitate their slow process. He noticed that it evolved gradually into experiential functioning: clients started to have feelings and to express them with symbolic language.

Psychological contact

Therapy did not work for psychotic clients, because one condition was lacking: they had no 'psychological contact' (Prouty, 1976; Rogers, 1957). Prouty distinguished three dimensions of psychological contact: *reality contact* (with the world, people, places, events); *affective contact* (with one's self, one's feelings); and *communicative contact* (ability to express experience to others). Psychotic clients have poor contact with reality. Occupied by hallucinations, they are not aware where they are, and hardly notice other people. They don't notice their body, body posture, or how they are dressed. They have poor awareness of themselves, their thoughts and feelings. They are unable to communicate properly with others by words or gestures. Dissociating clients have similar handicaps. Their process is slow. They lose contact with reality. Awareness of time is interrupted, they forget where they have been. During flashbacks or switches, they think they are in another time. They are confused from their switches in consciousness. Others don't understand their contradictory behaviour, find them crazy and avoid them. Clients have poor affective contact: their feelings are either numb or very strong. They do everything not to feel, by switching or self-mutilation. Their 'experiencing is frozen' (Gendlin, 1964). They have also difficulty in expressing feelings in understandable language.

Therapeutic language of pre-experiential phase

The first phase is characterized by its slow process. The client needs time to stay in touch with it. Therapists should not respond quickly, but repeat slowly what the client said. They assist by keeping track, especially when clients are interrupted by switches. The process has very tiny steps. Traumatization is so complex and multilayered, that change can only happen in small steps. Every step has many consequences inside the client. The process is also cyclical and repetitive as aspects of trauma come back, as well as behaviour and interaction due to the multilayering of trauma. Prouty underlined the importance of repetition. It may seem at a standstill, but it is a cyclical recurring of something which seeks to be expressed. While the same words are used, each repetition subtly reveals another aspect of the same content. The cyclical pattern is like a screw for metal, which needs many turns to get deeper. The first phase requires patience, but clients expect miracles. They want relief as they have

suffered for a long time. They try to work hard, but fear their trauma at the same time. One explains to them that their suffering needs relief, but that change can happen slowly. I use the image of a dance group. When the whole group turns, the dancer in the middle (pivot) turns slowly, lest dancers at the outside will be thrown out of the circle. I shall listen to all. We need a safe relationship first, which needs time. In the context of a relationship, the trauma can be told and change can happen. I call it 'pacing and extrapolation': I try to gain time, and to postpone intensive work to a later phase.

Another aspect of the first phase is its communication. Utterances of clients are preexpressive, and have not yet meaning in the usual sense. They become understood later in therapy. These need just literal reflections, without change, addition or interpretation. This technique involves a typical language. The few words are only those the client can utter. They are preserved as scarce jewels and reflected literally. Clients become confused when one asks questions about what they said. They get put off track by any straight question. It leads to discussion of personalities inside. Their process becomes interrupted. Whenever I need to ask something, I ask the question aloud to myself: 'I wonder what happened that you did not come last week.' I leave space for the client to respond, or to the personality inside who wants to speak. There is space to respond or not, and also space in time: I am not in a hurry. Sometimes I begin to answer the question myself and I imagine what could have happened. It gives space to the client to correct my hypothesis.

Pre-Therapy

The process of the first phase is assisted by 'Pre-Therapy' (Prouty, 1976, 1994). Pre-therapy addresses the client's lack of psychological contact. It 'anchors' the client with environment, therapist and herself (Van Werde, 1998a). It restores contact, which enables the client to have feelings. Pre-therapy consists of *'contact reflections'*. They contain Rogers' attitudes, using the language of confused clients. They respond to rudiments of contact clients still have, and are offered at their level. Contact reflections point to aspects of the client's experience, behaviour or existence: to reality, affective and communicative contact. *'Situational reflections'* point to reality: 'We are sitting in this room,' 'It is cold here.' The client may nod, look outside, or not respond. We trust that a vague awareness of reality is supported. *'Body reflections'* point to body awareness: 'You are sitting upright,' 'Your body is very stiff,' 'Your hands are on your knees.' The therapist can take the same posture with his body: 'body mirroring', and add verbal body reflections. It assists the awareness of the client's body, contact with self and with reality. Other reflections are *'facial reflections'*: 'You look surprised.' One reflects what is visible on the client's face. It is a neutral description without interpretation or suggestion. It helps the client to contact feelings. *'Word-for-word reflections'* are literal repetitions of the client's words. You said: 'darkness', and then 'away'. Literal reflections support the client's damaged ability to communicate.

Dissociative clients are interrupted often by internal voices. 'Wordfor- word-reflections' help to get back what they were saying. The last type of reflections are *'reiterative reflections'*. Those reflections that were followed by response or change of the client are repeated. One assumes that there was a move in process. Reiterative reflections reinforce that move. When a client looks at you (contact) after a body reflection, you repeat that body reflection, and you reflect the following eye-contact.

Repetition is a typical aspect of pre-therapy. A client who was elsewhere with his/her mind and who missed reflections hears them at a later moment. Other characteristic is are its slow speed and the time between reflections. Clients need time to hear, to process, and to respond. Moreover, the pre-experiential process is not linear. One does not see direct responses after reflections; it takes time. Then responses one did not expect come from the client. Sentences don't seem to connect with previous utterances. It can confuse therapists since it is unlike a therapy, in which responses follow interventions and can be discussed. It is more like minimal music. The same applies to the effect of pre-therapy. The bucket needs

many drips before it is full. Recently, Prouty (1999) stressed that pre-therapy is not just a technique; rather it is an attitude. Its core is the therapist's human presence.

Prouty's contribution has implications for the whole field of therapy. Not only psychotic clients could profit from it. Contact reflections are basic, and support other interventions. They are helpful to trauma clients, when they need a basis from which to endure strong feelings. Summarizing: the general character of pre-therapy is slow, repetitive and literal; it's specific quality is it's focus on contact.

B. Pre-symbolic process: a concrete process

Prouty called an hallucinatory image: a 'Pre-Symbol' (Prouty, 1977; 1986; 1991). 'Pre-' refers to its primitive nature. A Pre-Symbol (hallucination) does not symbolize or mean anything in the usual sense. It is a concrete phenomenon: it just means itself. It needs concrete language. An hallucination is not a projection like images in dreams, but an *extra*-jection: a split-off part of the client's ego. It doesn't refer symbolically to previous experience, and cannot be interpreted. It refers to itself. Prouty watched hallucinations as phenomena, without interpretation: to his surprise, a process started and hallucinations began to change. They became realistic and evolved into previous traumatic experience, which had been frozen. Hallucinations began to make sense, and contained fragments of real experience. First, they were 'pre-expressive' utterances (Prouty, 1998): they announced a message, which became understood later.

This approach of hallucinations is called: '*Pre-Symbolic Process*'. It has four stages. The first is the 'self-indicating stage', in which a hallucination becomes present.1 The client sees a hallucinatory image. He looks at the corner of the room; his eyes are directed to there. The therapist reflects: 'You look over there. You see something.' The client describes the image (colour, shape): 'It's big, round and yellow.' The therapist reflects that: 'image reflecting'. Image reflections are repeated. It assists to get the hallucination stable. Then, the client enters the second, 'self-emotive stage': he observes affect in the image: 'It's big, round and yellow, and it has anger in it.' The therapist reflects both image and affect. Reflections of image are balanced with those of affect. Slowly, the image loses its abstract or strange shape and becomes a realistic image of persons or events: it is the third or 'self-processing stage'. The hallucination is still outside, but the client begins to have feelings inside. He is puzzled seeing something there and feeling inside too. Gradually, the hallucination changes into a former real experience, often a traumatic flashback (Prouty, 1983). Clients are shocked to realize that something happened to them. The therapist reflects all these aspects. There is onset of symbolic and experiential language. Instead of being frightened by the strange hallucination, the client is impressed by the old repressed or split experience. Time is needed to integrate it. This happens in the fourth or 'self-integrating stage', when the process has become experiential, and the language symbolic. The therapist facilitates integration with client-centered/experiential reflections.

Dissociating clients have a similar process, especially in the first phase of therapy. They are attacked by flashbacks, over which they have no control. They cannot express or process them either. Due to dissociative barriers and fragmentation, they don't recognize flashbacks as part of *their* trauma. Flashbacks are also split in dimension (Braun, 1986): clients have physical sensations of strangulation without an image of the event; they see a dangerous scene without feeling anything. They don't understand. Flashbacks recur, like hallucinations of psychotic patients. Traumatic flashbacks frighten and evoke strong emotions. Clients don't talk about it: they expect not to be believed, as they never were before. They fear they are crazy, and suffer in isolation. Contact-reflections create a climate where flashbacks are welcome. These reflections support another aspect too. The emotional impact of flashbacks is not only due to the severity of the trauma, but also to the fact that clients suffer alone. They lost contact with the environment, other persons and themselves; they fear they might explode, and switch into another identity who doesn't feel. They reacted this way during the

trauma and do so afterwards during flashbacks. With contact-reflections, one assists clients to endure strong feelings. One reconnects the client and does not run away.

1. Hallucinations attack clients like nightmares and ‘daymares’ (Prouty, 1994). They come and go. Clients don’t talk about it, fearing more medication if they do. It needs an open attitude. Prouty stressed a second precondition. To enter a process, hallucinations need to be present and stable, for which Pre-therapy provides a basis (Prouty, 1990). When the client feels contact, the hallucination can stay, and a process can follow.

The stages of the Pre-Symbolic Process are observable with dissociating clients. First, there are mere fragments; or parts of fragments: sensations without image, images without feelings. It is the ‘self-indicating stage’. One reflects what is expressed, without inquiring about the traumatic event. That story will come. One picks up fragments and gives them a number as an archeologist. Gradually feelings become connected with images, and fragments get more fragments. This is typical for the second ‘self-emotive stage’. Clients become curious about what happened and about the origin of their suffering.

A client hallucinated her father (perpetrator) whenever she came home from therapy. He stood in the corner of the room. She was frightened and puzzled, as he had died. I dropped my inclination to control the hallucination, and attended to it. The hallucination appeared in the therapy room and it changed: now she felt her fathers’ presence in her body with physical sensations. Memories and context come back. Flashbacks become complete and become a story of trauma. Clients are shocked to realize that they have been traumatized, but begin to understand the reason for their complaints. This is reassuring: they were not stupid, and their memory is still there. The process follows the ‘self-processing stage’ of Prouty, which will be called here ‘the critical episode’. Clients are no longer split into alters. They suffer, facing the trauma fully, and they realize its impact on their life. They have difficulty integrating all the facts they somehow knew. Integration will be realized in the second, experiential phase, which parallels Prouty’s ‘self-integrative stage’.

The concept of ‘Pre-Symbolic Process’ fits into the therapy process of dissociating clients. Its first two stages can be observed during ‘phase I’ (pre-experiential, pre-symbolic). One does not enter into the content of trauma fragments but attends to them in a concrete an phenomenological way. One trusts the process. Trauma fragments will tell their story in a later phase. Contact reflections provide a basis; slow and concrete pre-symbolic reflections support the process, having the effect of ‘pacing and extrapolation’. One slows down the hectic experience of flashbacks, and facilitates a process which the client can digest.

3. SHIFT TO INTEGRATING: A CRITICAL EPISODE

When clients leave the first phase, they enter a no man’s land. They begin to have feelings, but are not yet able to stay with them. This episode, between phase I and II, is what Van Werde (1998b) calls ‘the grey-zone’. Clients become able to feel and to express feelings in symbolic language but they cannot practice it yet. It is totally new to have feelings, and to be in a climate where feelings are accepted. Moreover, clients begin to remember. Amnesic gaps become smaller and memory less fragmented. They can no longer ignore facts or doubt the reason for their suffering: they must admit they were traumatized. They cannot switch as easily as before. Switching loses its purpose, as dissociative barriers become transparent. Alters cannot persist to deny the trauma. Switching becomes a burden rather than a help, and the clients want it to stop. Although clients are improving, they have difficulty handling the trauma, and are not ready to integrate it. First, they still tend not to feel. Second, they never had feelings in the presence of a person who is safe. Third, they are afraid to face the trauma, because they were brainwashed. They were supposed not to believe they were abused. They were threatened (with abandonment, death, or hell) not to tell what happened. They fear betraying and losing their parents, if they admit that their parents betrayed or abused them. They are confused. Moreover, their full memory of the trauma comes back as a flashback.

New details are so fresh that the trauma seems to recur. It is shocking and too much. Clients enter a period of severe crisis and need support. Therapists don't expect it, as their clients were improving. They should not go on leave without replacement. Extra calls or sessions are needed; sometimes a short admission. During the critical episode, contact-reflections (pretherapy) assist clients to remain connected. One can return to slow literal reflections (preexperiential and pre-symbolic language) which slows down their hectic process. Symbolic language is reflected, without exploring the trauma. Integration will happen in the second, experiential phase.

4. PHASE II

A. Experiencing and focusing: healing from the body

When clients enter the second, experiential phase, they have contact with their feelings. They remember the trauma, have to face it and to work it through. Their traumatic memory has to change into a narrative memory (v. d. Kolk, 1996). Flashbacks in which the trauma recur, become trauma events which *have* happened. It becomes the past. Then clients can look at it as a story which they remember. They can describe it with words without drowning. The trauma has to get a place and meaning, and must become integrated. Intensive cathartic sessions are not necessary. Integration can happen with small experiential steps. When one is assisted to stay with an anxiety-provoking situation and to feel the crux of it, one feels relief (Gendlin, 1964). The secret of experiential psychotherapy lies in its tiny steps (Gendlin, 1990). When one makes an experiential step with a single word, a problem feels totally different. Attending to the felt complexity ('felt sense') of a problem and finding the right word for it, gives a 'felt shift'. One feels that the problem is moving towards its solution. It feels as a relief. It is different from 'dead-end thinking', or being submerged in 'dead-end feelings' (Gendlin, 1996). A nice illustration was given recently by Elliott and colleagues with a therapy fragment. A change in the client's voice could be heard when she said: 'So the fear is like a thing!' Something fell into its place. It sounded like a turning point (Elliott, Slatick and Urman, 2000).

Focusing (Gendlin, 1981) helps clients to attend to their felt sense. The felt sense is a vague physical feeling, in the middle of the body, about a problematic situation. It becomes clear if one attends to it. It is both feeling and understanding the problem: it is the felt crux of it. Traumatization is so complex that it cannot be described with a single word. But it can be felt at one spot in the body. When clients attend to this felt complexity, they catch the core and they feel relief. *Then* they have a catharsis with release of emotions, which is different from abreactive catharsis. Therefore, clients are encouraged to focus, which they could not do in the first phase. Clients find it important to capture the typical atmosphere in which the trauma happened (Coffeng, 1992a, b and c). It is the 'flavour' of their experience. Experiential words and responses fit with the complexity and specificity of traumatization. The therapeutic language changes from pre-experiential to experiential (Gendlin, 1968).

The body

A benefit of focusing is its trust in the body. The trauma happened to the body of the client. Physical and emotional abuse was felt in the body. The body carries the traces (Terr, 1994; Putnam, 1999; van der Kolk, 1996). It is the source of memory and has the hallmark of facts: it is the center of truth (Pesso, 1990). When the client reconstructs her trauma experience from the different traces (images, sensations, diary, witnesses), she can check with her felt sense if it happened. The body also has the hallmark of another truth. It has a moral blueprint (Gendlin, 1991/92/94, 1993), which tells us that the trauma should not have happened; it knows what should have happened. Moreover, the body is the source of healing. Recovery comes from the body with small steps which are felt. Trauma clients denied their body and avoided feeling. As soon as they can stay with their feelings, they realize that what they felt was true. They begin to trust feelings, and discover that their body knew it. They feel that the process moves forward, and become confident. They notice improvement and discover more

facts. A client re-experienced being raped when she was four. She described strong feelings: it burst in her pelvis, her heart pounded as if it exploded, it went to her head, she fell in a black hole, and then she died. I reflected that it felt as if she died. She shouted: 'I had died!' She believed she had died. Afterwards, she asked with surprise: 'But I did not die for real, did I ?'

Focusing language: body language

As the body is crucial, it is important to communicate with it. Focusing language points to the client's bodily felt sense. Questions of the therapist are directed to the client's body. The client repeats these questions inside, and waits for the body's answer. The answer is translated into language the therapist can understand. The body is the client's client (Gendlin, 1984). When clients begin to trust their body, they dare to practice focusing. The first step, clearing a space, gives a time-out when feelings are overwhelming. It is a moment to feel good, a safe place from which to watch their trauma. It helps to pace. The second step, getting a felt sense, makes a distinction between strong emotions and vague experiential feelings. The last carry the core of their trauma, and are felt under strong emotions. A client noticed a vague feeling under her strong emotions. It was the first time she had contact with it. She knew it had been there, and recognized it now as a 'felt sense'. Before, she was scared to feel and got upset by focusing words. Now she felt what was under the emotions: she had contact with her integrated self. The third step, finding a handle, gives the key to the felt sense. Clients feel strength and relief when they can name the crux of their trauma. By the fourth step, resonating, they feel a reinforcement of that relief, and a shift. They feel they are surviving and are getting further. The fifth step, asking, helps to ask new questions: what did really happen and what did matter, instead of what they had to believe. The sixth step, receiving, reinforces the experiential step (shift), and it helps to pace. Clients are vulnerable just after a shift, and may become 'structure-bound' (Coffeng, 1991; Iberg, 1981). Critical voices in their head destroy the shift. It happens often to trauma clients. The experiential shift is so new that they become anxious and tend to split again. Dominating alters take over. The sixth step is a break. One stays with the last felt shift and blocks the door against critical voices or top-alters.

Holding and containment.

It is hard for clients to stand strong feelings when they face their trauma. They fear they may explode and lose control. For such situations Pesso offers a holding technique. Group members hold the client. They form a container for strong feelings and connect the client with the ground. They protect the client's boundaries and form an 'ego-wrapping' (Pesso, 1988). It enables the client to process feelings. Such group members are absent in individual therapy, and the only one who could hold is the therapist. Physical contact, however, is condemned by many therapists, who suppose it would do harm to the symbolic or professional nature of therapy. Others distinguish between therapeutic and non-therapeutic contact, and they argue that physical contact can be symbolic, professional and a skill. They give guidelines and preconditions, so that contact becomes therapeutic and safe (Bohun, Ahern and Kiely, 1990; Durana, 1998; Hunter and Struwe, 1998; Pesso, 1984; Prouty, 1983). One precondition is the client's boundary (Olsen, 1982/83). Clients have their territory with a spatial boundary around it: it can be felt. By moving their chair clients can assess the boundary between them and therapist. They feel and check which distance is right. Focusing helps to define it (Gray, 1988). The therapist promises not to cross their border without their explicit permission. When clients experience this respect and feel they are in charge, they will ask the therapist to come near or to hold them when needed. Therapists should verbalize every step before doing it, and the client can check it. Whenever a client indicates to stop, or when it is unclear, the therapist steps backwards. Respect of the boundary makes holding safe.

Anxiety, pain and sadness

Three affective modes become apparent in the second phase. At first, confrontation with the trauma evokes shock and anxiety. Clients can no longer split when they face the event. It is

followed by intensive pain when they refeel the abuse and see their beliefs collapse.

Afterwards they enter a period of sadness and grief. They realize that emotionally they lost their parents, their innocence, childhood, and many following years due to their suffering. Before, they held to the belief that their parents loved them. When therapists recognize the affective mode, they find the right tone of support and understanding. Anxiety needs a specific support; pain needs a different response, and so does sadness. The pattern of these three affective modes can be observed in subsequent sessions, sometimes within one session.

B. Symbolic experiencing: the power of images

In the second phase of therapy, the memory of clients about the trauma is no longer fragmented. Meanwhile, their process has become symbolic as well. It corresponds with the 'self-integrating stage' of Prouty's Pre-Symbolic Process. Instead of dissociating, clients feel the crux of their experience and they can give words to it. They can express what it did to them. It is different from what they believed. They find different words. Words and images become symbolic: they have a meaning and capture the emotional and cognitive aspects of the client's experience. The right words bring relief and have an experiential effect: they carry the client's experiencing forward. They need experiential reflections (Gendlin, 1968), which convey not only compassion, but also sensitivity of the context of the trauma. The therapeutic language is symbolic.

In this phase, previous words of the clients come back, but now with a meaning: they have become symbolic. The therapist begins to understand what previous pre-symbolic words meant, and the events to which they referred. In the first phase the client was still 'preexpressive' (Prouty, 1999) and could use only condensed telegraphic words. Words which were strange before begin to make sense now and appear to have been a key. Previously frozen words come alive and have meaning. It is the most interesting aspect of the Pre-Symbolic Process.

Imagery

Not only the traumatic events can be expressed in symbolic and semantic language; the recovery from the trauma needs symbolic language as well. Imagery is a powerful instrument. Words have a limitation, as they are associated with thinking. Clients tend to think what they were supposed to think. Criticized by internal voices, they become entangled in 'structure bound' or 'dead-end' functioning (Gendlin, 1996). Olsen introduced imagery (Gendlin and Olsen, 1970). Images and symbols often catch the crux of a felt sense better than words. At the same time they leave space for different meanings. They give also emotional space and perspective. Imagery, which was helpful for clients with grief, appears to fit trauma clients as well (Coffeng, 1992; Santen, 1993). They discover its power and their own symbolic energy.

Reconstructing the past

A precondition for recovery is to re-establish the truth: to confirm that the trauma happened. Clients were forced to deny the truth. There was no witness. It is crucial for them to have a person who can testify what happened. Pesso (1990) introduces a group member who acts as a witness: he confirms what happened and expresses that it was bad. Symbolically he is a witness who should have been present at the time of the trauma. He supports the client to believe her eyes and her felt sense. In individual therapy a witness can be imagined. The therapist verbalizes what a witness would say. The image can be extended into a court, where a witness testifies before the judge. The client is shocked to believe her memory, but she is reassured that what she felt was true.

Gendlin (1991/92/94, 1993) introduced the concept of the 'blue print'. It is the body's sense of what is needed. Not only physically (food) or emotionally (contact), but also the need for truth. The blue print knows what happened. A child knows if something is correctly

named or not. Clients were forced to disbelieve what they felt and to suppress their blue print. When the truth can be said, the blue print gets air. It confirms what happened. The 'blue print' has also to do with moral rules. It knows what is right or wrong. Children should not be abused, the truth not be distorted, lies not be believed. The body knows what should not, and what should have happened. This inner morality was suppressed, as clients had to accept false rules from people on whom they depended. It is important to restore the 'blue print' with proper moral rules. One says: 'It (trauma) should not have happened!' Clients are asked: 'What should have happened?' When they don't know, therapists assist to imagine it and clients check inside. Their 'blue print' is the basis. This way, there is no risk that therapists impose new rules.

Gendlin (1994) mentions two realities. One reality is that the trauma happened. This statement is relieving: what the client felt was true. Another reality is that it should not have happened and to find out what should have happened. Clients are mixed up by these two realities. They are loyal to false rules of caregivers, and cannot believe normal parents exist. They think all parents are like their parents. It helps to make a distinction between the reality of what happened and the reality of what should have happened. It is done by the following statements: 'It did happen. It is bad that it happened. It should not have happened.' Then one asks: 'What should have happened?' Clients consult their blue print and make it concrete with an image.

Clients need alternatives for the trauma and its context, having no idea of a normal and safe family. In Pesso-therapy, group members act as 'ideal parents', saying what normal parents should say. Clients can feel contact with normal parents. This new experience restores the blue print. In individual therapy, clients must imagine ideal parents with their fantasy. Therapists assist to make it concrete. They verbalize what normal parents would do and say. Clients check inside if it fits. Reconstruction is the bulk of the second phase. Clients have strong loyal ties with former caregivers and perpetrators. They cling to their lies. It takes time and repetition to correct it and to rephrase proper moral rules.

Symbolic energy

The second phase has two sides. It is heavy, as clients face the full reality of the trauma. Having strong feelings, they try to understand how it could have happened, realizing the betrayal. On the other hand, they feel their feet on firm soil, since the truth is confirmed. They discover the power of imagery. They can imagine what should have happened, which was suppressed before as an illusion. Clients have a tremendous symbolic energy. They need hardly to be encouraged. They bring dolls to act as witnesses. They have dolls to protect them at home. They use a towel as an 'ego-skin'. They make drawings when talking is difficult. They bring tapes with music they find comforting. One client showed a drawing of her foot. She had made it after a dream in which she was invisible. Before, she made herself invisible by walking on her toes. Now, the drawing symbolized that she could stand on her feet and be present. While the integration of the trauma takes much energy, energy comes back with imagery.

Integration

Grief and sadness dominate the second phase. Clients realize they have had no proper caregivers and no safe childhood. A whole part of their life is wasted by the consequences of the trauma. When a child, there was no one to whom they could express their grief. Now, there is a place for it. Grief feelings can be channelled with focusing and imagery. Clients imagine ceremonies in which they part from perpetrators, caregivers, and other aspects of their past. They find consolation. They realize it is the past. They no longer have anxiety about the present or future. Instead of frightful flashbacks, they have a narrative memory of the traumatic past. It is an important change. Tears become the water to clean false concepts and to clear the way to new concepts and new persons with whom to relate. Much has to be integrated.

Clients have become capable of doing so since they can focus. They find trust in their feelings: what they felt was right. They find power in symbols and images. With the help of imagery, words become cleaned from their old meaning and get new meanings and perspectives.

5. CONCLUSION

Different modes of experiencing have been described, which correspond to sequential therapy phases of dissociative clients. In the first phase, the process is pre-experiential, pre-symbolic, repetitive and slow. Dissociation is prominent. A critical episode announces the second phase, in which the process becomes experiential and symbolic. The client's affect changes from anxiety and pain to sadness. When these phases are recognized, one can adapt to the client's process with one's tone, language and speed. Words which are used in a symbolic way can be taken literally by the client. If therapists adjust their language in time, crises can be prevented. In fact, crises may give feedback about previous interventions.

The presented model differs from the official treatment model of dissociation (van der Hart, van der Kolk and Boon, 1998). The latter is phasic too, but rather it is a program to be followed, than one that follows the client's process. The therapy of multiple trauma has many other aspects. The relationship and (counter-)transference have special qualities (McCann and Coletti, 1994). There are techniques to contact the different identities of DID-clients (Chu, 1994). This therapy, intensive and long lasting, has to be embedded in a network. Therapists need co-therapists; clients need friends or others for assistance. All these aspects could not be discussed here, but they can be found elsewhere (Kluft and Fine, 1993; Putnam, 1989; Ross, 1997).

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