Bereaved and traumatized clients: can we give them hope? 1)

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Abstract:

Looking back at his therapeutic work with bereaved and traumatized clients, the author found eight concepts that had been helpful as therapeutic tools. These concepts or ‘principles’ offered a basis for therapy. Some helped clients to settle and therapists to relax. Others gave clients a frame for expressing feelings, while they helped therapists to get a picture of the client’s context. These eight principles are: the tendency to avoid victims, the primacy of human contact, the expertise of clients, the creation of a place, different types of reality, the use of imagery, the mechanism of pacing and finally, the use of a roundabout. Each of them will be described and illustrated with examples. Focusing-oriented therapists consider the body as the source of therapeutic change. The body of bereaved and traumatized clients seemed to be also the source of recovery and perspective. In this sense, hope was facilitated.

Introduction

There is not much hope in what bereaved and traumatized clients have undergone. Their stories don't make you optimistic. When you work with them, it is different. With the company of a listener, these clients may engage in a recovery process that is full of energy. You don't need to bring optimism, it comes from the clients themselves. Often, people try to say something hopeful to victims, in an effort to cheer them up. It has the opposite effect: victims feel obliged to change their mood, which they can't. Instead of giving them hope, I offer tools in therapy. These tools or principles are intended to provide a basis. They reconnect clients with their inner source of recovery. They help therapists to relax. Being at ease, therapists can find their own way of working with clients. The same principles can be also as a basis for adding special therapeutic techniques. These techniques become more effective then.

Some concepts came from Gendlin (1991-1992-1994; 1993; 1996); others from Prouty (1994; 2008) and Pesso (1988;1990). The origin of other concepts will be mentioned in the text. They were used in the author's therapy with bereaved and traumatized clients during the past years. These therapies had a client-centered and experiential or Focusing-oriented character. A discussion of other approaches of trauma and grief would be beyond the scope of this article. It can be found elsewhere (Coffeng, 2002a+b; Draijer & van Zon, 2013; van der Hart & Nijenhuis, 2006; 2007; Jacobs, 1999; Rando, 1993).

1. The first principle: The tendency to avoid victims, and the willingness to help

We don't want to be confronted with shocking and bad events. We cannot avoid the daily news, but we can switch off the TV if we want. Seeing traumatized persons themselves is another reality. On your way to the waiting room for collecting a client, you may have mixed feelings as you anticipate going to hear horrible stories. The tendency to avoid trauma, death or disease, is a human reaction. The analyst van Dantzig (1999) pointed at this typical mechanism. You want to run away from a traffic accident. You must force yourself to go there for help. You feel relieved when the ambulance is there already. As a consequence, we avoid also persons with a loss or trauma. People look away when they meet them on the street. The bereaved notice it; they feel left alone . When not being left alone, they would not suffer so much. They need contact. Parkes (2001) showed the positive effect on widows and widowers, who were visited by social worksers. They had less medical and emotional problems than those without visits. It requires an extra human step to overcome one's tendency to avoid, and to approach victims, according to van Dantzig. This step is a gift already: you are not running away.

Once, I was involved in a car accident. I was in a shock, hardly believing I survived it. A man came to my car. He gave his mobile to me, saying: 'Use it as long as you need. I stay with you until there is help'. I felt his care.

The willingness to help has implications. Therefore, I added some preconditions.
1.1. Free choice. Offering help is a free choice, whatever my considerations are. I am free to help, but I am free also to refuse. It may not feel good to see a client with a problematic grief when I have more bereaved clients already. Helping is is a free choice and not a duty. When I would be obliged to help, the victim would feel guilty. We are equal. The possibility to refuse enlarges my capacity to help: when I am free to refuse now, it will be easier for me to help at another time.

1.2. Limits. One reason of avoiding to help may be the fear of getting involved too much or being committed too long. It is good, therefore, to set limits. My offer of help is an offer for some time. It does not mean that I shall help forever.
Another point is that I am free to stop when I want. The victim should not feel dependent on me. We are equal. I keep company for some time, but I cannot promise to stay until the end. It is also important to make clear to clients when I am available and when not.

1.3. Break. I take care of the client ánd of myself. My capacity to listen has limits. When it is hard to hear more, I may ask for a break.
Once, I asked a client to stop. I could not stand it any longer to hear his horrible story. I ran to the window to get fresh air. The man looked surprized: he had felt nothing!

A break can be an interruption of some weeks during an intensive therapy. Most clients accept it, and we can continue with therapy afterwards without problems.The freedom to stop or interrupt therapy may give comments of colleagues, but it enlarges my capacity to help.

Clients don't feel guilty. It is reassuring to them that I take care of myself. A break can be realized more easily in a network of therapists. When a colleague wants to replace you, you feel it in your shoulders. It gives a relief. On the other hand, you may replace him when he needs a holiday. So far the first principle: the tendency to avoid and the freedom to help.

2. Second principle: 'The two chairs of Gendlin'
the primacy of human presence.

Two conditions seem to be basic for working with bereaved and traumatized clients: the attitude of the helper and the offer of contact. Gendlin formulated it nicely at the first PCE in Leuven (1988):

'I want to start with the most important thing I have to say: The essence of working with another person is to be present as a living being. And that is lucky, because if we had to be smart, or good or mature, or wise, then we would probably be in trouble. But what matters is not that. What matters is to be a human being with another human being, to recognizes the other person as another being in there….' (Gendlin, 1990,p.205)

'…So, when I sit down with someone, I take my troubles and feelings and put them over here, on one side, close, because I might need them'. …'And I take all the things I have learnt – client-centered therapy, reflection, focusing, Gestalt, psycho-analytic concepts and everything else (…) – and I put them over here, on my other side, close. The I am just here, with my eyes, and there is this other being.' ….'I do not need to be emotionally secure and firmly present. I just need to be present. There are no qualifications for the kind of person I must be. What is wanted for the big therapy process, the big development process is a person who will be present. And so I have gradually become convinced that even I can be that.'
(Gendlin, 1990, p.205)

Having been there that day, I remember that Gendlin said more. In the first minutes of his speech, he took us to his consulting room in imagination. He placed two chairs together on the stage: the chair of the client and that of the therapist. I did not find this part in the above chapter, so I give in my words what he said:

'When you anticipate seeing a client, you arrange the chairs in your office or change something on your desk. Those minutes before the client enters, something happens: the interaction has started already. You don't feel the same as before and the client feels different too.'

Human contact is the best we can offer. We don't need to be clever or smart or experts. When we offer contact, interaction can happen. Since interaction is supposed to be related to change, it is the essential part of therapy. When we enable interaction to happen, we do what we can. This principle is valid also in the contact with traumatized and bereaved clients. What Gendlin said is reasuring for therapists who are unsure if their help will be sufficient. I remember anxious faces of young psychologists when I was teaching. They felt uncomfortable and incompetent. They assumed they lacked the skills for seeing trauma clients. It tried to convince them that they had the main quality in themselves already: their human presence.

Gendlin's principle of the two chairs is linked to the following principle.

3. Third principle: The client is the expert

Expertise of clients

Bohart (2012) underlined the expertise of clients. In his view, they have an inner agent that guides their process and the direction of their process. They have their own way of solving a problem. Trauma clients would agree. Having survived all kinds of hardship, they have the experience of what was helpful and what not (Coffeng,1996). Clients can guide the therapist by giving feedback of what works.

Unique process

Bereaved people appear to have many ways of dealing with their loss (Stroebe, Schut & Stroebe, 2005). It is contrary to the traditional assumption, that clients should be confronted with the loss and urged to express emotions (Ramsay, 1977). Not only is the manner of grieving unique with each client, so are the circumstances of the death in each case (Rando, 1993). The same seem to apply to the recovery from a trauma. One client may need a supportive approach, while the other requires a more confronting technique (Coffeng, 2004).

Individual pace

Attention should be paid to the pace of each client. We check with the client regularly, if it is going all right. Sometimes it is good to stop a session early, or to have a break. Some clients want a week off. They need to recover from intensive sessions. We come bak to pacing afterwards.

4. Fourth principle: A place

4.1. Place of the trauma - place of the loss

Working on a trauma needs a place: the location where it happened. Bereaved people need to know where their relative died. It has to be real. Knowing the place, helps clients to get concrete feelings, and therapists to imagine what happened. Gendlin used to say: 'Let's go *there* (Gendlin,1991; 1992;1994). He meant: Let's go to that place in you that was hurt. It could mean also: Let's go back to that place where something happened.
In the case of *trauma*, the client's flashbacks with intense emotions have to change into a memory with feelings that are more differentiated: the traumatic memory has to become a narrative memory. By creating a picture of the place, the therapist helps to see the trauma in its context. Then, the client can have new feelings that are specific for that event, and that are based on the felt sense. The articulation of those feelings gives an experiential shift, - a change that is felt-, and a relief. Afterwards, one sees the traumatic event in its historical context: it happened there and then. 'The place' helps therapists to imagine what happened. Initially, they have no idea of the event and its context. With picture of the place, they can imagine it and empathize with the client. In the case of a *loss*, the place is important also. Bereaved people need to know where the relative died. It has to be real.

For one client, the place had to be very real. He could not end therapy before I had gone with him to the street where his wife had died in a traffic accident. For me, the confrontation was shocking, but the client felt much better. Now, he was able to say farewell to his wife.

For those who had a loss in childhood, the place of death is unclear often. Children may get poor information about the dying relative or they get it late. They are not told that their parent

is dying. Some are denied acces to the hospital or funeral. They cannot see the dead parent or sibling. When adults, they have a mist of sadness in their body, without a clear memory of the loss. They don't realize the mist is about the loss. They look surprized when you make that connection. I help clients to reconstruct what happened. I encourage them to find relatives, neighbours etc. who remember the events.

A client found a retired teacher who remembered the funeral. She described how her sister lied in state and the people at the ceremony. With that reconstruction the client could imagine asif she had been there.

Atlas

War refugees have experienced losses ánd traumas. They are in a new environment, far from where they lived. Except from relatives that died, they lost belongings and their context. They are unsure about their stay in the host country. They are displaced. As a therapist, I need to have a picture of their place of origin. I want to reconnect them with that place. So I have an atlas at my office, and ask them to show where they lived. Refugees become alive. They point to the map and tell about their village and family (Coffeng, 2004).

4.2. Place of justice: place of working on the trauma
Memorial: place of mourning

Place of justice

Trauma victims need another place where they can express feelings about what happened, and say what they need to say. We imagine a court in the therapy room, where things can be said and justice can be done. The therapist states what a judge would say. Pesso(1990) introduced *the witness*, a person who testifies what happened. He confirms what the client has told. A witness is crucial, since clients were confronted often with disbelief or denial. They are relieved when somebody testifies they were right. A witness is created in the therapy room, where the therapist expresses what a witness would say.

Memorial: place of mourning

Bereaved clients need a grave where deceased person is buried, or a memorial. It is a place where things can be said to the deceased: a place of communication. A client may want to lay flowers there or to light a candle. Another wants to rearrange something on the grave or change the inscription on the stone. These steps can be made in imagination in the therapy room. Sometimes, it helps to make a drawing. Clients check with Focusing which actions fit.

Imaginary memorial. Refugees don't have such a place. They don't know of the bodies of their dead relatives were found or buried. We can help with imagery.

A client came from a war. He had escaped from a heavy fight. Having to run for his life, he had been unable to bury companions who had died. There bodies were left on the battlefield. The client felt guilty about it. With the help of the atlas we found the place. I asked him to describe the place and the fight. While recounting, he seemed to be there again. I set fire to a piece of paper, symbolizing the fight. When the paper was burnt, I said the fight was over. I suggested to bury the dead and to have a ceremony. He wrote the name of each companion on a sheet of paper. I laid the sheets on the ground, asif these were the dead companions. Together, we buried them one by one, in imagination. Finally, he rose from his chair and

adressed each of them with a speech. Then he nodded that we could move on. At the end of the session, he focused on what we had done and it felt O.K. (Coffeng, 2004).

Real memorial. Van Hest (2012) did a step that was more concrete. Working with severily traumatized refugees, he felt they needed a place to mourn. On the compound of his hospital, he found an old monument that was not used any more. He asked permission to re-instate it as a memorial for refugees.There, he organized ceremonies for them with real priests. These rituals helped clients to end their clinical therapy.

5 Fifth principle: Reality

Coming from an area where nothing was safe, trauma clients need a safe place and a firm ground. Coming from a place where nobody could be trusted, they need a reliable person. Therapists should be honest: they don't say that a place is safe, when it is not. Trying to compensate for the loss or trauma, therapists tend to mitigate its severity in their words, or they avoid to mention crucial events. Clients however, appreciate it when therapists are realistic and call things by their names.

5.1. The two realities of Gendlin, and the blue print

Gendlin (1993) made a distinction between two types of reality. The first is the reality of what happened, the facts. It is important to recognize that these events happened. The second reality is that of the ideal situation, the reality of what should have happened. For that second reality, Gendlin (1993) introduced the concept of the *blue print*. It is an inner body feeling that acts as a compass. The body knows what is right or wrong. It knows that bad things should not have happened. It knows also what should have happened instead. Focusing gives acces to the blue print. We ask the client's body: 'What should have happened?' or 'What would feel right?' We wait for the body's answer.

The first reality: the facts

Perpetrators of child abuse tend to deny what they did. Family members join them in their denial because of loyalty (Spiegel,1986). Victims encounter denial and disbelief from others. It made them unsure of their memory (Coffeng,1996). On the other hand, these clients have an inner urge to find evidence of what they remember. They want to know the origin of their complaints. They look for somebody who can confirm what happened.

The need of finding the truth was crucial for one client. She survived many traumas, having a severe form of dissociation. It appeared that the traumas themselves had not led so much to dissociation. She dissociated on moments she encountered denial from others, when she confronted them with facts. In spite of this, she pursued her journey for justice. She tried to find people that were responsible and witnesses. However, most doors were closed. For instance, she asked photos from her childhood to help her memory. Her mother gave the album, but without the crucial pictures. She denied having removed them, saying it was not important. My client's dissociation became worse. The final blow came with the suïcide of the client's brother. The client tried to see his therapist, wanting to hear what had happened. She was denied access to him. His superior asked me to discourage my client's search. He was concerned it might lead to further inquiry. Something was covered up. As a consequence, the dissociation of my client became bad: she could not speak for almost a year!

The blue print and the truth, memory.
It has not been stated by Gendlin, but I think the concept of *the blue print* may include the inner need to find the truth and the facts, or the need to get confirmation of memories that were lost (Terr,1994) . It is the case with trauma clients with amnesia. It fits also to clients with a loss in childhood whose memory has gaps because of poor information at that early time. The therapist can help to recontruct what happened. He tries to get an imagine of the place and the events, and offer this as an hypothesis. Clients can check with their inner blue print, if this reconstruction fits (Coffeng, 1992).

Gendlin's second reality: what should have happened?
The body knows what a child needs from a parent. It knows how an normal parent should act. A therapist can assist the client by suggesting what a good parent would do and the client's blue print can confirm if his hypothesis is right. In the same spirit, Pesso (1988) offers the figures of ideal parents. Groupmembers take that role. They verbalize what an ideal parent would say. Clients check in their body if it fits. These ideal parents are not fairy-tale figures. They behave like proper parents would do, as confirmed by the client's blue print. The notion of two realities is helpful for clients who have mixed feelings about their parents. They are angry about what their parents did. Their anger increased when these parents denied the facts. They feel attached to them at the same time. It is helpful when they can split: when they can feel attached to the ideal parents they would have had, and be angry to their real parents at the same time.

5.2. Two existential realities

When seeing victims of severe and repeated trauma, therapists have to deal with different kinds of reality, the reality of the trauma and the reality of everyday life. There is a gap between these realities. It places therapist and client for the question how to deal with this problem. We discuss the gap between realities within the client, and the gap between the reality of the client and that of the therapist.

5.2.1. The existential gap in the clients themselves
La Mother (2001) and Laub & Auerhahn (1993) descibed holocaust survivors who had no full access to their memory. The trauma was so overwhelming that their coping system collapsed. Moreover, there was no empathic person at that moment. There were no words to describe the impact of the disaster. The trauma became a not-integrated memory, or an *inexperienced experience.* Clients could give an accurate account of the events, but their memory lacked the emotional impact of the experience. At other moments, these clients had nightmares of the trauma, with all emotions involved. Afterwards, they were amnestic of it. There is a gap between these two realities. Others speak of a dissociative split (van der Hart, Nijenhuis & Steele, 2006).

5.2.2. Existential gap between client and therapist
There is another gap. The gap between the reality of the trauma survivor and that of the therapist (Bluhm, 1999; Laub & Auerhahn, 1993; La Mothe, 2001). Clients come from a traumatic world, where rules and events were completely different from that of the 'normal'world. Things occured one could not imagine.There are no words to describe those events in the language of the 'normal' world, being the world of the therapist. As for the therapist, it is hard to imagine what happened and what the client went through. We should

acknowledge this gap. Staying with these clients and hearing their stories, requires an emotional engagement. We discussed it in the first paragraph. It does not leave therapists unaffected. Their sense of 'reality'will include that other experience (Dasberg, 1991; van der Kolk et al, 1996).

6. Sixth principle: Imagery

Olsen introduced imagery in Focusing (Gendlin & Olsen,1970). With the second step of Focusing, we wait for *the felt sense*: a body sense that has the felt meaning of an issue (Gendlin,1981). When the felt sense is present, we continue with the third step, that of *finding a handle*. We wait for a word or phrase that captures the crux of what is felt. When the right words come, they act as a handle of the felt sense: they may carry it forward so that it can change. Olsen suggests an alternative third step. Instead of asking for words, she asks if there is an image or symbol that relates to the felt sense. The image becomes the handle then. Imagery was not only an enrichment to the focusing process, it was a valuable instrument also in therapies of trauma and grief (Coffeng, 1992; 1996). I like to discuss its value on various aspects.

6.1. *Images and symbols imply more aspects of experience than words.* Words have a certain meaning or connotation. Images have more meanings and associations.

6.2. *Images have the power of creativity.* They offer a perspective of new possibilities.

6.3. *Images come quickly and spontaneously.* Words come later, usually. The image functions as a bridge between the felt sense that is present, and words that come later. When words come, they become the new handle, together with the image.

6.4. *Imagery creates space.* It gives air. We can imagine what we need and organize it as we want. There are not limits. We don't look at the limits of reality. The only check is the body: it will respond when it fits. We may add another step to make it more concrete. We ask the body how it would feel if we imagine ourselves in that theorethical place. It helps to carry the process forward.

6.5. *If combined with focusing,* imagery is not like daydreaming, unlimited phantasy, a flight from reality or an illusion. The images are checked with the felt sense (Gendlin, 1996).
It is different from the floating of thoughts.

6.6. *Bereaved clients* find it easier to express feelings in images than in words. Words connect to old emotions, so grieving clients may slip back into dead-end feelings or dead-end thinking, with self reproach and guilt (Gendlin,1996). Trauma clients may get flashbacks. Images open a new way with the possiblity of repair. When the deceased was buried in a wrong way, we can do the funeral again, in imagination, and have it as we wish.

A client was unhappy about the way her parents were buried. We created a new funeral. She would have it her way. She wanted the music of Miles Davis. Her father had liked it She could hear it in her imagination and she smiled (Coffeng,1992; 1994a).

6.7. *Imagery can be combined with the blue print*. In the stories of loss and trauma, many things went wrong. The body knows 'what should have happened' and clients can imagine it. They create an image of that possibility and check with their felt sense if that feels right.

6.8 *With imagery, one can make a distinction* between the place of what happened wrongly, and the other (blue print) place of what should have happened. One can create a space between those two places. The external image of space corresponds with an inner feeling of space.

6.9. *Clearing a space with imagery*. McGuire (1984a+b) invented an alternative way of the first step of Focusing, 'Clearing a Space'. She asked clients if there was a moment in their life when things were OK. When clients remembered such an event, McGuire invited them to think of it and to imagine it. When the memory was vivid, she proposed to travel with them to that place in imagination. She helped clients to protect that imaginary place by keeping their problems (trauma) at a distance. Clients felt an inner space. From the imaginary place, they could look at their problems (trauma), without being overwhelmed.

A client had a recent trauma. By entering my room, she seemed more dead than alive. She was in a shock: her face was pale and had no expression; her body had no movement. When I asked what happened, she gave an account of the events with a monotone voice. I asked where she came from. She described the place she was born where her father had an orchard with cherries. It was springtime and the picture of blossoms came to me: I imagined what she saw when a child. While we discussed it, the client became alive. I suggested we would go to that place in imagination and enjoy the cherries. She closed her eyes and seemed to travel with me. Her face relaxed with a smile. Then, I asked her to attend to the center of her body, and sense how it felt to be in the orchard. After a silence, she began to shake all over. I asked if she was OK and she replied: 'Wait!' After some time, she opened her eyes with a deep sigh. She shaked again asif she removed dust from her body. Then she looked at me, saying: 'So…that feels much better!' She smiled. She had space. Next session, another person entered my room: lively and with more colour on her face. She had slept well and felt much better. She had stopped all medication without any side effect. It appeared she had made many change steps at home, just by herself.

6.10. *Creativity*. Creativity is connected with imagery. A lot of it can be found in clients with a grief or a trauma. They are inventive in ways to express feelings.They make drawings, paintings, sculptures, etc. They do it spontaneously. Some objects are symbolic, others have a concrete meaning.

A client brought a picture of a blue sky with golden stars. She had been afraid that she would disappear in space, whenever she dissociated. The other day, she discovered that the sky with stars could be seen as a roof. The roof could protect her from going any further and getting lost. This notion was reassuring to her. The picture was as an expression of it and she kept it as a reminder.

Another client came with an outline of her feet on paper. She made it after a dream. In the dream, she had felt that her feet reached the soil. It was new: she had contact with the ground! She would not dissociate any longer or float in the air. It was a big advancement. The picture was evidence of this step. She was happy and proud.

7. Seventh principle: Pacing

Pacing is indispensable in every therapy, and so is the notion of phases. Therapeutic interventions need to correspond with the stage of the client's process. A response that seems to be wrong at one moment, may fit in a later stage. The content of the response could have been correct, but in an *experiential* sense, it was wrong or too early. In a later session, a client may come back to what you have said and confirm that you were right! In that later phase, it is recognized internally.

7.1. Iberg's experiential phases

Iberg's model of experiential phases is helpful as a map for pacing. He developed it for using focusing in therapy without interrupting the therapyprocess. He offered specific responses that correspond with the phase of the client. They facilitate that clients have contact with their feelings. The model has three phases: 1. *The structure bound phase,* 2. *The parturient phase,* and 3. *The nascent phase*. The phases correspond with the stages of the focusing process. A description of the phases and interventions will not be given here. It can be found elsewhere (Iberg,1997; Coffeng,1991; 1994a; Coffeng &Vlerick, 2008)

7.2. Phases of early grief: re-cycling

Another phasic model was developed for adults who had a loss in childhood (Coffeng,1992; 1994b+c; 1995). The grief of children can be disrupted easily. The effect is a split of the child's ego: one part accepts the death, the other denies it (Bowlby, 1961; 1980). Secretly, the child remains connected with the dead parent or sibling. The grief is postponed . The stranded grief interferes with the child's emotional development (Nagera, 1970). When these children are adults, the old grief is hardly accessible. Clients have a notion of the loss, but is is not connected with feelings.They have emotional problems, but don't relate that to the early loss. When you make that connection, they look surprized. These adults need a therapy with attention to the early loss. The focus alternates between development items and grief. It gives the therapy a cyclical pattern. A second cyclical pattern exists at the level of experiencing. At first, the loss is accepted intellectually. Gradualy clients get acces to memories and feelings, with some awareness that the loss was theirs. In a later phase, details of the loss return, but more as a reality: the grief is owned. Clients feel again as a child. A third cyclical pattern corresponds with the early mechanim of splitting: denial and acceptance alternate. A fourth cyclical pattern is due the emotional volatility of children (Mahler et al, 1961). Children can be upset at one moment, but seem to forget it afterwards. These alternating moods can be observed in adults with early grief. A fifth cyclical pattern refers to the therapy as a whole. Clients may come back after some time, because parts of the early loss came to the surface. It helps to have a notion of these cyclical patterns. Similar cyclical patterns can be observed in the therapy of clients with an early trauma (Coffeng, 2005).

7.3 Pacing at a micro-level.

In the session itself, we pay attention to the speed of the therapyprocess. We check with the client regularly if he/she coping with the process of change. Is he/she able to digest a part of the trauma or grief. Does he/she need a break? From an experiential perspective, a feeling-process needs to be settled first, before intellectual understanding can come. When the client has contact with feelings at the end of the hour, and has no words to express them, we

surpress our tendency to explain it. We trust the process. At the next session, the client will tell you what it was about.

8. Eighth principle: 'roundabout'

Suppose you are driving a car and approaching a roundabout on the highway. When you don't know which direction to go, you become nervous. The traffic can make it worse. Once, it happened to me, nearing a roundabout of a big city: I panicked. That moment, my wife told me: 'Just go around, as many times as you need, until we find out where to go.' I did as she told and after some rounds we found the right turn off. I use the same principle in therapy. There can be sessions of an impasse, when nothing seems to help and you don't know what to do. On those moments, I stay with the client, turning in circles, until I see something I could use. Sometimes, the client finds a way out. I don't know solutions always. What I can, is to keep company. As a psychiatrist, I was trained the other way.

A client who had problems with ending the session in time. I tried many tricks. I asked her husband to collect her at the end of the hour. It worked for some time but the problem returned. I was desperate. After some weeks, she came with an alarmclock, proposing to set it at the start of the session. The problem was solved.

Another client became silent after a year of therapy. She was irritable also: whatever I said seemed to be wrong. I just kept company. After a few months, she relaxed. She explaned her irritability had to do with angry feelings towards her father. It was a transference problem. The air was clear.

It may be hard to keep company, when a client is silent or not communicating. You want to be useful as a therapist. It is frustrating, when you don't get reactions from your client. You don't know if your responses were right. Perhaps the client prefered that you would be silent. You don't know. You feel helpless. Gendlin (1967) described something like a roundabout, when he was seeing psychotic and silent clients. He felt he could do nothing else than to keep company. Meanwhile, he said what came up in to his mind. Another and more specific approach of being with not-communicating clients is that of Prouty. He introduced therapeutic tools: *contact-reflections* (Prouty, 1994; 2008) . His approach fits to the contact with dissociative clients who cannot speak for some time. When you notice that clients opened their eyes or changed their body posture, you verbalize what you see: these are contact-reflections. These reflections help clients to get contact with themselves. Since this process is slow and repetitive, you don't expect immediate response. It may come after some time. Prouty's approach helped me to notice what happens. It made me feel useful during silent times. It helped me also to be patient (Coffeng, 2002 a+b).

An example of Prouty's approach is a client who could not speak for a long time. She came twice a week, sitting silent on her chair. I kept company with contact reflections. After one year, she announced that she wanted to draw. I felt something was going to happen. Next session, she indicated that she wanted to sit on the ground; more specific: under my desk. After a silence (and contact-reflections), she said she wanted to draw. While drawing, she explained what the picture was about. She was talking again! The video of that session was shown in Lisbon (1997) and Chicago (2000).

The roundabout can be used also before a therapy starts: when you are considering to invite a client. If you have mixed feelings about it, you may need time to think it over.

9. Summary

We discussed eight principles for the therapy of clients with grief and trauma. We began with the tendency to avoid victims and the extra effort it requires to overcome that tendency. We suggested a structure for helping, with limits and conditions. We continued with the primacy of human contact as it was symbolized by Gendlin with two chairs. We joined Bohart in his emphasis on the expertise of clients and trust in the client's process. We introduced the concept of a place for expressing feelings: a place of justice and another place of mourning. We formulated the two realities of Gendlin, that of the facts and that of the blue print. We added existential reality that is connected with severe trauma. We discussed its implications for therapists. We recommended the use of imagery, a powerful instrument that gives space and energy. It is a source of creativity and hope. We adviced to be aware of phases, to ensure that our responses fit to the client mode of experiencing. It helps the timing of interventions. Finally, we introduced the idea of a roundabout to be used by therapists on moments of despair.

10. Discussion

We started with the question if we can facilitate hope in the therapy of trauma and grief. Our answer is that the source of hope can be found in clients themselves. Therapists don't need to offer it. What they can offer are conditions that enable clients to recover. Our eight principles are part of it.

For therapists: they feel relieved when we state that helping is a free choice and that their help may have limits.They are not convicted to it. Seeing the client as the expert, brings relief also. We cannot know everything. We just need to be honest and realistic. Without those duties, therapists can relax and be themselves. In that condition, they get acces to their own creativity. Offering company to a person who is traumatized or bereaved, is a gift already. One does not run away. Clients find a place to tell their story, and a person who believes them. The listener is like a witness. I think these are plenty reasons for hope.

On the side of the client: there are reasons for hope also. So is the client's body the place where emotions are felt that relate to a trauma or loss. The body knows to process those feelings and to express them in words, images, or motion. The body is the place where recovery originates and from where new steps come. The client's 'blue print' knows what is right. Clients feel it in their body. When asking 'What should have happened?' , the body will respond. Clients have their own inventions and creativity. Despite their sad stories, these expressions are signs of energy, movement and creativity.

The distinction between the reality of what happened and of what should have happened, gives air. Clients tend to mix traumatic memories with ideal images.They mix the parent they had with the parent they wished to have had. The spatial distinction between the real parent and the ideal parent, gives air. There is space between these two different images outside, and corresponding internal feelings. They are no longer mixed up. The question 'What should have happened?' does not lead to illusions. It corresponds with the other reality of the 'blue print', according to Gendlin. It restores the function of the blue print, a feeling of what is right or wrong. It helps clients who, having been brainwashed when a child, adopted false moral rules (Coffeng,1996). By offering company, we help clients to attend to their body sense in a friendly way. Wel help to restore the contact with themselves. It opens to new steps.

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Notes

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