View of Self as a Guiding Lens in a Trauma Case

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In the treatment of trauma literature in the United States, an exciting convergence of ideas from researchers, psychotherapists, and theorists is underway. Strategies from various disciplines including neurobiology, developmental psychology, attachment theory, traumatology, systems theory and others are being woven into new approaches to aid in healing processes for trauma victims (e.g. Fosha, 2000, 2002; Siegel and Solomon, 2002; Minton, Ogden, Pain, and Siegal, 2006; Najavits, 2002, van der Kolk, B.A., 2002). In areas of the world where violence due to political or social upheaval has left a history of trauma across a region, some of these approaches will undoubtedly prove to be invaluable.

Unresolved trauma can have far reaching impact. Recent findings in the U.S. point to "Second-Generation" effects, where the offspring of traumatized parents, who do not mistreat their children, still may perpetuate psychological distress (Hesse, Main, Abrams, and Rifkin, 2002). That is to say trauma's influence is not limited to its immediate victims, but also ripples outward to impact others in the social network of any victim, thus spreading possible harm across individuals and generations. Victims of trauma may experience significant psychological distress and yet not fully meet the definition for PTSD. Van der Kolk (2002) identifies lingering issues that can result from trauma such as affect dysregulation, aggression against self and others, amnesia and dissociation, somatization, depression, distrust, shame, and self-hatred.

A flexible tool

Supplying tools for psychotherapists to cope effectively with the psychological impact of trauma is urgent. This article suggests a conceptualization of treatment options from the construct of the patient's internalized view of self rather than addressing the patient's needs from a fixed theoretical perspective. This conceptual tool assists the clinician in balancing the various idiosyncratic needs of the individual patient who seeks help and allows the therapist to create safety in the therapeutic relationship while working with intense emotions.

Researchers in the U.S. have suggested patients who effectively change their view of self achieve mental health benefit regardless of treatment approaches (Castonguay, 2000). A relatively new area of concern identified by researchers in the U.S. calls for attention to the negative effects of psychological treatment and cautions psychotherapy educators to instruct trainees in *potentially harmful therapies/treatments* (Barlow, 2010; Dimidjian and Hollan, 2010; Castonguay, Boswell, Castantino, Goldfried, and Hill, 2010; Lilienfeld, 2007) in addition to offering training in empirically supported interventions. The notion that we must identify what *not to do* as well as *what to do* is gaining needed attention. A key area of concern focuses on the harmful effects of the rigid application of any therapy model (empirically validated models are included) without the clinician's attunement to the patient's particular and immediate need (Castonguay, Boswell, Castantino, Goldfried, and Hill, 2010). In such cases the psychotherapist persists in interventions that can inhibit change rather than promote it. The authors strongly recommend *clinical flexibility*.

I argue that the conceptualization of the view of self as expressed in the patient's narrative presents a tool that clinicians can use across therapy modalities that emphasizes tracking the patient's responses to interventions and promotes this recommended flexibility. A case study will demonstrate application of this construct.

Hovering attention

Researchers and theorists in the U.S. delineate how early negative experiences may alter the development of brain structure and function and can now propose models for how experience shapes the prefrontal cortex of the brain. Findings indicate that the prefrontal cortex can act as "the mediator" of risk in the aftermath of traumatic experience. The amygdala encodes fear in our brain and researchers

propose that interaction with the prefrontal circuits allows for the extinction of fear. In situations of acute trauma, the amygdale fear response may be adaptively moderated by the prefrontal cortex in the majority of individuals who do not develop PTSD (85%), but for others (approximately 15% of the population by U.S. estimates) the recovery from trauma is thwarted possibly by earlier experiences that impair the capacity of the individual's prefrontal cortex to respond to new overpowering experiences (Siegel and Solomon, 2002). The mind becomes inflexible if trauma has disrupted the integrative qualities of the brain as the authors suggest and self-regulation can be negatively impacted. This means that clinical decisions about treatment options for trauma patients can be complex and models or protocols for treatment must be administered with careful flexibility to meet the unique needs of each patient.

The feedback from neurobiology research points to the need for the psychotherapist to find a means to explore early experience with patients, often experience that was painful, while at the same time helping the patient to cope with panic or other symptoms in their current experience (see Siegel, 1999, 2001 for a discussion of the interface between relationship experiences and the structure and function of the brain). These patients are already distressed and are experiencing inflexibility in their mental functioning and adaptivity, so engaging patients in this work can be challenging. Safety must be experienced in the therapy relationship and environment for this process of healing to progress (Bloom, 1997; Bloom and Summer, 2000).

Using the construct of the patient's view of self can offer a means to engage the patient in the collaborative process of exploring his/her early experience to identify how these experiences are impacting the patient's post trauma coping. Millon (1999) provides this definition of the self:

> The diffuse swirl of events that buffet the young child gives way over time to an increasing sense of order and continuity. The most significant configuration that imposes a measure of sameness on a previously more fluid environment is self-as-object, a distinct, ever-present, and identifiable "I" or "me." Self-identity, the image of who we are, provides a stable anchor to serve as a guidepost that creates continuity in an ever-changing world. Although few can articulate clearly the psychic elements that constitute this sense of self, it serves to color favorably or unfavorably the nature of one's continuing experiences (p. 34).

Although amorphously defined in psychological literature, as Millon noted, the identifiable "I" is an essential conceptual commonality across various psychotherapy approaches. Particularly in the object relations and self psychology schools of psychodynamic thought, the self is a regularly accepted component of human personality (Kernberg, 1984; Kohut, 1984; McWilliams, 1994; Winnicott, 1965) and the focal point of much of the therapeutic change process. Kohut (1984) wrote,

> When I speak of the "cure" of the self in this context, my statement is in harmony with my conviction that the psychological health of this core of the personality is always best defined in terms of structural completeness, that is, that we should speak of having achieved a cure when an energic continuum in the center of the personality has been established and the unfolding of a productive life has thus become a realizable possibility (p.7).

In working with trauma patients, I propose using the patient's descriptions of him/her self (implicit or explicit in the patient's narrative) as a means to invite the patient into a collaborative exploration of current and past experience that contributes to his/her present difficulties. This suggestion can be applied regardless of the general therapeutic approach that the psychotherapist employs. Further I would suggest that the work of psychotherapy, particularly the *flexible* approach recommended for dealing with trauma patients, demands a kind of juggling of attention from moment to moment in the immediacy of the therapeutic encounter.

Much of the skill that the therapist provides to be helpful to patients centers on a concept that Freud labeled "hovering attention" (in Pine, 1990). The therapist listens carefully to the patient's stories and associations with an open awareness of several means of organizing the patient's narrative data, including the ongoing awareness of the biological emergency responses that persist for the trauma

patient. It is as though the therapist becomes skilled at juggling (Pine's metaphor) the data offered by the patient, at one time focusing on the conflicts evidenced in the material and moments later shifting attention to the object relations the client suggests or the coping strategies and defenses emerging in the data or in the moment of the therapy itself. As a juggler must pass each ball through his hands in succession while being mindful of the other balls in the air, so the therapist's attention hovers over the material conceptualizing it in a variety of ways in order to best understand the patient and address immediate needs.

The argument might be made that a clinician cannot do multiple tasks at once. The essence of hovering attention is that the shifts allow the therapist to organize the formulation of the patient's material in a way that draws strength from *all* that is presented. Theories have broadened and changed since Freud originated the phrase, but there is nothing to indicate that this approach to patient material cannot function only more broadly given the added richness of neurobiological and trauma related theory emerging today. Juggling various viewpoints in organizing patient narrative data does not mean variations in techniques are employed that contradict one another. Instead the emphasis is on listening and understanding the full range of data given by the patient.

As Pine (1990) described in his use of the four streams of psychoanalytic theory, substantive content and the mechanisms described in interpretations that are highlighted by the different streams of theory are all attended to rather than an "application" of any one theory. Josephs (1995) echoes this line of thinking as well, noting its postmodern sensibility. Theories may mirror distinct points of view, but when considered in turn, when juggled to continue the metaphor employed here, they can enrich the process of psychotherapy. This ability to listen to a wide range of aspects of the patient dialogue by giving hovering attention enhances the formulation process for the therapist. "All individuals have experiences of many shapes and the multiple perspectives of the several psychologies are well suited to address them all, and certainly better suited to do so than any one alone" (Pine, p. 52). Therefore, the suggested tool of integrating view of self into the care offered to trauma patients is designed to offer a flexible framework for hovering attention to the therapist so that s/he may draw strength from various therapies that could be helpful in bringing relief and healing to trauma patients.

Ways to use the view of self

A few comments about my basic assumptions will set the stage for the case study demonstrating the use of the view of self in working with a trauma case.

Early experiences. First as purposed above, patients' early experiences with caregivers shape their developing psychological processes and solidify patterns of thought, feeling, and behavior that carry across their lives. The symptoms of trauma that the patient experiences grow out of the systems that developed early in life and remain because of the cycle of reinforcement contained in interpretations/appraisals the patient continues to assign to external reality. The patient's current subjective experience is determined by cognitive and affective systems of interpreting external data from the environment that mirror past internalized impressions. So trauma symptoms could be characterized as defensive processes/coping strategies that have gone wrong due to the overwhelming trauma situation(s) with the persistence of biological emergency responses and the repetitive and reactive internal appraisal processing that continues after the incident(s).

Defenses. Another way to conceptualize this defensive functioning is to view it from the perspective of the patient's means of protecting self-esteem and self-cohesion (a sense of him or herself as a single, whole unit). From this perspective the individual's responses or defenses, also, reflect repeated situations occurring in the patient's early, dependent stages of development. The patient's internalized models of self and other color his/her analysis and expectations of the traumatic event and any situations that follow. A wide array of new, adaptive options to meet the needs and desires of ongoing adult life are available to the trauma patient, but for this individual to choose such new options s/he must be able to respond to current conditions "uncontaminated by the past" (Pine, 1985), which includes the past trauma event(s) as well as the patient's developmental history. Ongoing symptoms could be characterized in part as the contamination of the past in present functioning. This includes contamination of the cognitive processing

systems as well as the intrapsychic processes of the individual, both of which are reflected in the patient's view self and other.

Schemas. The concept of schemas (A. Beck, 1987, 1989; J. Beck, 1995, Freeman, 1992, Young, 1994) is central to the construct of the view of self as I use it here. Schemas/core beliefs, the mental maps or models of self and other, form the cognitive and affective structures that produce survival responses. Without these models to predict environmental outcomes, the individual could not function; however, schemas/core beliefs are viewed as being formed in response to early needs, often deficits in the environment and care-giving experienced by the patient. So schemas represent a major cognitive conceptualization of how survival and growth are possible for humans and they also ironically represent the core of psychopathological development. When trauma occurs, the patient's systems of coping are overwhelmed and the view of self and other is marked by fear, even terror. Symptoms may mask deeper sources of pathology. For example, a patient may hold a core belief about the self that she is bad. Children develop negative views of self in their attempts to make sense or meaning out of trauma, either severe or chronic. Believing that the self is bad is a more psychologically soothing choice than believing that the caregivers on whom the child is dependent for survival are bad. This belief about the self is carried forward into adulthood; however, a belief that the self is bad is not a comfortable psychological message for the individual to consciously cope with in daily life so she forms strategies to deal with this belief. She may develop habits of seeking to do the right thing in every situation in order to counteract the now hidden schema that she is bad. The rigid internalized need to be right could easily lead to the client becoming mired in patterns of behavior and feeling that are counterproductive to her mental health. She could work long hours and demand perfection of herself. Any mistakes could trigger severe pathological symptoms of self-punishment or deprivation or perhaps she is able to cope more adaptively and avoid symptoms while still carrying the negative view of self. Over the course of time, the client would overdevelop certain coping strategies and neglect others entirely. She could in these ways remain unaware of the core view of self (schema) and may attend exclusively to pursuing perfection or create a series of other maladaptive responses to external reality, some of which may appear to be normal or functional. Her cognitive processes, however, become biased. If a traumatic event(s) is introduced in the life of such an individual, havoc can ensue as she attempts to process the trauma with an unconscious view of herself as bad/alone, which influences her subsequent thoughts, feelings, and behavioral choices.

The patient's internalized templates of self (a view of the other is always implied as well) reside at the core or schema level of mental processing. They represent conflicts *in* the self (i.e. longing for autonomy while impulsively acting in dependent ways that link to a view of the self as inadequate alone/bad) as well as conflicts the self experienced with others (i.e. viewing others as invasive and so impulsively isolating from interactive initiatives from others). These templates at the core of the personality lead to rigid rules and assumptions at the intermediate level of mental processing, which in turn lead to the problematic ways that clients may think, feel, and behave at the more surface or preconscious levels of mental functioning (the automatic thought level of cognitive therapy formulation, e.g. A.Beck, 1989, J.Beck 1995). This is where symptoms are demonstrated in the patient, that is to say, where psychopathology is exhibited.

In trauma cases the added component of the biological responses that are internally stimulated by benign external triggers that have been associated with the trauma experience adds complexity to the recovery work. The construct presented here proposes that the emergence of problematic thoughts, feelings, and behaviors starts within the unconscious mental functioning of the individual in schemas set in place early in development and continuously shaped by processes of defensive functioning (including biased cognitive processes) meant to protect the individual from the unconscious core beliefs about self and the strategies the individual created during his/her development to cope with the overwhelming affect associated with these schemas.

Maladaptive processes. Table 1 gives an overview of the maladaptive processes that form the basis of psychopathology, reflecting cognitive formulation of thoughts and psychodynamic formulation of drive, defense, and the internalization of self and other. Brief examples are included using a symbiotic/dependent patient to parallel the case study presented below. While working with a trauma patient, the therapist must attend to the symptoms, but also explore ways to help the patient free herself

from restrictive patterns of thinking, feeling, and behaving that reinforce symptomatology in order to achieve long standing change. Working with the view of self can provide a helpful framework for this exploration.

Maintaining the schema (core belief of self) is paradoxically the dreaded and the wished for outcome, the conflict in the self. Problems around the regulation of the self, maintenance of self-esteem and cohesion impact these internalized templates. Patients unconsciously use their defensive processes to maintain the sense of self that is acceptable or tolerable to them, that is, they think, feel, and behave in ways that are syntonic with their conscious view of self represented at level 1 on Table 1. The individual will interpret her thoughts, feelings, and behavior as normal and justified. At this level of functioning the individual may be viewed as attempting to support her conscious self representation and unable to see the pathological repetitions of thought, feeling, and behavior that cause such distress in her life.

Under closer examination, however, it becomes clear that the individual is responding in ways that are not adaptive and functional. The relied on defensive processes are repeated due to information processing issues in the brain itself and because at deeper levels of psychological functioning, another very different view of self (the dreaded view of the schema in Table 1) creates on-going anxiety so that no amount of support is enough at the self-syntonic level. The repetitions continue and often become more desperate as anxiety continues to emanate from the schema. Problematic responses that patients encounter in themselves and others perplex them. In very simple terms, they cannot see themselves accurately. The individual's defensive strategies aim to keep the core view of self out of consciousness while the patient simultaneously and unconsciously strives to gain support or comfort for the deficient self that the schema represents.

Table 1 Representations of the View of Self and Levels of Mental Functioning

Level 1 – Preconscious Thought and Experience – Automatic Thought
"Supporting the Self-Syntonic View"

- Thoughts - Automatic (accessible to conscious thought with training): "I must/should . . ."
- Feelings - Identifiable emotional patterns: "Yes, I often end up feeling that way."
- Behaviors - Patterns of behavioral strategies that support the individual's accepted view of self and others: "He expects me to be there for him. I always am."
- View of Self – acceptable (not necessarily "positive") self representation – efficacy/agency: "I help others in need. I want to take care of him. It isn't a burden to me. This is a good thing to do."
- View of Others – acceptable representation of Other – affirmation for view of self: "He needs me."

Level 2 – Unconscious Ego Function/Defense – Coping Strategies
"Preventing the Self-Dystonic View"

- Thoughts – Assumptions and Rules to live by (If/then statements): "If I take care of him, then he will be there for me."
- Feelings – Unconscious emotional patterns: repeated desperate defensive quality to affect activated unconsciously in order to prevent painful recognition of schema. "I do all I can, give up my very self, but still he doesn't stay. I'm nothing without him."
- Behaviors – Unconscious behavioral patterns: repeated desperate defensive quality to behavior activated unconsciously to prevent painful recognition of schema. "I must stay close at all costs."
- View of Self – Self-dystonic, desperate self representation which negates the consciously acceptable view of self from level 1. "I'm no good without him."
- View of Other – representation of others that negates consciously acceptable view of self. "He must be convinced/coerced to stay with me."

Level 3 – Schema – Unconscious, Internalized Self and Other – Core Belief "Self as Horror"

- Thoughts – Unconscious core belief about the self: "I am fundamentally incapable."
- Feelings – desperately avoided affect states, representing intrapsychic conflict: dependency/autonomy in this example, overwhelming emotions: "Terror over abandonment."
- Behaviors – reflecting infantile wishes and urges (drives/id material) and mirroring self deficits (internalized self and object; self "wounds"): clinging, raging, acts of overt dependency.
- View of Self – core belief reflecting drive impulses, ego defense breakdown, object relations, and self deficits: "I am incapable alone. Alone I will die."
- View of Other – core belief affirming dread represented in view of self: "He will abandon me."

Add the biological emergency responses that may accompany this process in trauma patients and the desperation experienced by the patient becomes clear. It is unmet needs for attachment, differentiation, and an attuned environment that formed these internalized and dreaded models/beliefs about self and thus psychopathology has its roots in the core view of self, the schema. Another way to describe the experience of the trauma victim would be to say that in addition to the external horror of the traumatic event(s) with all the physical shock/threat/harm, the patient also had to contend with the internal horror of the threat/damage to the sense of self, both the functional aspects of the view of self and the dysfunctional aspects described here.

It is worthy of note also that early studies of war trauma reference damage to the view of self. When Kardiner (1941) wrote of his experiences of treating World War I veterans, he noted that the patient, "acts as if the original traumatic situation were still in existence and engages in protective devises which failed on the original occasion. This means in effect that his conception of the outer world and *his conception of himself* have been permanently altered*"* (p. 82, *italics added*). Working with trauma patients using the construct of the view of self assists the therapist in engaging the individual in the affect laden work of *re-altering* the damaged view of self while monitoring the patient's reactions and restoring safety in the therapeutic relationship as needed. The following case study will further articulate the application of this construct.

View of Self (VOS) as a Lens for treatment: a Case Study

Sally, a single woman in her early twenties, came to therapy because she began to experience flashbacks to a traumatic event that had occurred several years earlier. When she was living overseas and on school trip, she and a group of her friends had been attacked at gun-point and taken to a secluded area where group members were sexually assaulted. As Sally told the story of this assault, I reflected various aspects of her view of herself as they emerged from her narrative. The initial view of self (VOS) that Sally presented was of a good daughter and friend, who strove to please others. She saw herself as a cooperative and helpful person. As I reflected this VOS to Sally, she expanded with more details about how this was important to her. We were at Level 1 of Table 1, the preconscious VOS or self-syntonic/acceptable VOS in the therapeutic dialog. She seemed to relax with this empathy and continued with her retelling of the incident.

At this level, patients feel understood and affirmed. Often, however, the more dystonic or unconscious VOS also emerges in the narrative. The therapist must decide when the therapeutic alliance has evolved to the degree that the patient will feel psychologically safe enough to explore the more distant VOS (Levels 2 & 3 on Table 1) and the more intense emotion that are associated with these. In the first session

I reflected only the Level 1 VOS. It was striking, however, how Sally seemed blind to her role as a key resister of the attack. She described being the first group member approached by the gunmen. She noted "thinking the guns weren't real" (a dissociative response signaling the depth of the trauma) and becoming enraged and defiant, refusing to comply with the gunmen's demands. They left her and ordered two other women from the group to move away from the others. These women were raped, but before other group members could be similarly assaulted, the gunmen heard the approach of people and ran away.

Sally seemed blind to her role in the attack as a strong, even brave resister, delaying the violence and thereby preventing it for some of the group members. The VOS as the supporter of others was a comfortable fit for her. Her actions of defiance and self-protection were not. She had no recognition of how the attackers had withdrawn from her, even though she repeated these details each time she retold the story of the attack. This became an important and pivotal point in the treatment as I will discuss below, but in the first session I did not press this more unconscious VOS.

Sally described the aftermath of the attack as being supportive with friends staying together all night and with school officials on the trip remaining available. When she arrived home, she remembered her parents also being supportive. She noted that she slept on her parents' bedroom floor for a couple of weeks after she returned. She was unable to be alone without significant distress.

The VOS of 'needing others' was obvious in her narrative and when I mirrored it back to Sally, she was comfortable affirming it. This is a hallmark of the Level 1 VOS. The rape victims received counseling after the attack and lots of support and attention from Sally's point of view, but others labeled Sally as "the lucky one" since she was not raped. She was not offered counseling. When I reflected this VOS as "lucky," Sally's response was intense. Tears filled her eyes and she became very quiet. Matching her tone, I slowly offered, "I don't think you feel like you were lucky at all." Sally's body language indicated great relief as her words of confusion and pain came spilling out.

In her confusion and fear at the time, Sally had turned to her parents for help. They were supportive, but also repeated to her that she had been "spared from the trauma." Sally and I explored what this was like for her. In the context of our work together she began to access more of the feelings of isolation and neglect she had suffered at the time, although she continued in a valiant attempt to maintain a picture of her parents as helpful and close. The Level 2 VOS was emerging. Sally was trying to be the good daughter, that is, to please her parents by doing as they asked, by "getting over it" and "moving on" since she was "spared." As Sally began to understand herself more fully and acknowledge her reactions to this trauma, including her legitimate need for support, both counseling and social support, her current symptoms decreased, but did not remit entirely.

Early in the treatment Sally spoke about herself: "I've always been a good student, but I'm finding it difficult to focus. I almost can't read any of my assignments any more. I get jittery. I start papers for school and I can't finish them. Why is this happening now? I got over that night long ago. I slept on my parents' bedroom floor after I got home. I cried a lot. But then I decided I need to push ahead with my life. I was making my parents really nervous when I was clinging to them. I didn't experience anything like the other girls who were raped. I needed to get a grip on myself and I thought I did. I told myself I had to listen to my mom when she said it was past and I was saved. It's been so long ago now. So why is this happening?"

Sally's VOS as a compliant, cooperative, kind person was tied closely to her experience with her parents. She wanted to please them in her childhood and as a young adult. We reflected on this together. As we did, Sally began to tell me about growing up overseas and going to boarding school from the time she was 8 years old through high school. As we talked about her VOS as the "good girl" she began to see all the ways she had buried many feelings in order to maintain that VOS. Even as a young child, she had tried not to cry when her mother and father left her for long periods of time at her boarding school. She remembered missing them terribly and feeling frightened and alone, but being told repeatedly by school staff not to make them feel bad by crying in front of them. The VOS as the good girl came to mean that she was to not cry and eventually to attempt to not need them so much.

Sally also began to talk about her relationship with her boyfriend, who I'll call Steve. Steve wanted to get engaged. Sally was very sure she loved Steve, but she felt paralyzed by the decision to marry him. Sally described Steve as an attentive partner. She liked his zest for living and his ambition to get ahead in the world. Steve reinforced Sally's VOS as a good person who was helpful. They had recently had some disagreements about plans for the future. Steve was already in medical school locally and Sally was undecided about her future career. She had expressed her desire to go abroad for the summer, but Steve didn't want her to be so far away. Sally thought this was "sweet," but also noted that she began to feel annoyed with him over little things like walking too fast which caused her to always feel rushed. She noted ways she often helped him with his laundry or other chores so they would have more time together, but she often felt disappointed when he was spending long hours on his school work. She felt guilty that she was disappointed.

The VOS at Level 1 was helpful and attentive, but her experience of herself with Steve was not always compatible with that. She kept doing helpful activities like the laundry, but she had begun to note that she felt resentful of doing these helpful acts. She had argued with him recently and felt very badly about expressing her anger. I noted that her VOS as the good daughter might also mean that she valued being the good girlfriend, too and that she tried to be good by doing things for Steve. This resonated with Sally and she seemed very engaged in the work, both emotionally and cognitively, so I pushed a bit further and suggested that perhaps the recent arguments were particularly hard for her because when she got mad, she no longer was trying to be good. We began to explore how she seemed to have a deeper sort of assumption about herself that if she failed to take care of Steve by ignoring her own feelings, she would end up alone, a Level 2 VOS. She could affirm this and linked it to how she had tried to be good by ignoring her feelings with her parents at the time of the trauma and earlier in the separation at boarding school. Making these links seemed to help Sally be in touch with her feelings, but also to manage them so that she didn't feel overwhelmed. Her reports of panic diminished further.

As I conceptualized Sally's inner world via the lens of her VOS, her unconscious conflict around autonomy issues became clear. Developmentally Sally was at the point of launching into her adult life and much of her turmoil seemed to connect with her fears related to these new steps. As she took action to employ new forms of self-care, she noticed how much of her energy she had spent trying to manage others by helping them. She began to wrestle with the Level 3 VOS as fundamentally incomplete and therefore unworthy of love and companionship. This core VOS carried with it the *sense* that she would die if she did not maintain the self-abrogating relationship style she had learned.

This VOS captures more than an irrational cognition that needed to be disputed, but indicates a more imaged-based, left hemisphere process as Fosha (2002) describes in her experiential work with emotion and relatedness. Sally's intense fear of abandonment drew its strength from this VOS. Her strategy/defense was to merge with others, by doing everything to please/help them while ignoring her own needs and desires, a form of self abandonment that ironically confirmed her dreaded VOS as alone. As she managed her anxiety through relaxation practices, and changed her interactions with Steve and others to be more honest about her own experience, she reported new excitement about her future.

As she was able to identify more of her genuine feelings in her relationships, Sally began to reprocess her feelings connected to the assault as well. It was at this point that a pivotal moment occurred in our work together. Sally and I were again talking about the night of the attack and she recounted the moment when she was first confronted by the gunmen and was defiant. She was particularly aware of feeling afraid as she retold the story. I noted what a remarkable response she had had. We had talked about the way trauma can impact different people and she remembered thinking the guns were not real and labeled that in this retelling of the story as "foolish." I stopped her then. I reflected the core VOS as incomplete and utterly dependent, and commented on how this VOS fit with her interpretation of herself as "foolish." I noted, however, that she had taken an independent action based on her anger in the moment and although we could not predict if that would be wise in every attack situation, in this instance, it had saved her from rape and perhaps had saved others since she had slowed the attackers' process with her disruption.

Sally was silent for some time. When she spoke, her voice was clear and direct. She seemed to me to be in touch with a new energy. She articulated a changed VOS. She noted that she didn't think she needed to abandon her anger any more. She began to talk about how she could use it instead. Then she quietly added, "Like I used it then." As we processed how hard it was for her to let herself know that she had acted in her own best interests, she sat in a relaxed manor and laughed about how she was learning to do that with Steve, as well. She was symptom free and her gains in therapy were maintained and strengthened through her final sessions with me.

Conclusion

In working with trauma survivors, the psychotherapist must manage the affect laden process of healing, balancing the need to activate genuine emotion while helping the patient to manage the overwhelming terror associated with the event(s). There is no healing without genuine engagement of emotion in the reparative safety of the therapeutic relationship (Fosha, 2002; van der Kolk, 2002). Consideration of the patient's VOS at the various levels of mental functioning can offer a helpful tool for the psychotherapist's conceptualization of the patient's inner turmoil and a helpful language to use with the patient to invite him/her to explore that inner world to bring healing.

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