Ellert Nijenhuis

The Trinity of Trauma: Ignorance, Fragility, and Control

Enactive Trauma Therapy

V&R

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Volume III

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Preface

It is impossible for man not to be a part of Nature and not to follow the common order of Nature. But if he lives among such individuals as agree with his nature, his power of acting will thereby be aided and encouraged. On the other hand, if he is among men who do not agree at all with his nature, he will hardly be able to accommodate himself to them without greatly changing himself.
Baruch Spinoza (1677a, Part IV, Appendix VII, p. 156)

Human action is the process of the intertwining of the body and the environment in cooperation with other people, and the results of human action are an inseparable part of this process. The human being belongs together with the other human beings and may only in this context have his own existence. Individuality is possible only in a social system.
Timo Järvilehto (2000a, p. 53)

Interpersonal neglect, maltreatment, and abuse can cut deep wounds, particularly when the misery commences in early childhood and lasts for years and years. Healing[1] the visible and invisible injuries in a later phase of life constitutes a profound challenge. Regaining wholeness without any aid from supportive others may be exceptionally difficult if not in fact impossible. A little help from friends rarely suffices to get by, and not even a lot of help from one's allies may do. Some individuals have not or scarcely experienced that other people can be caring and loving. If life has been this harsh to them, they may have major difficulty establishing or maintaining close relationships at all.

Strictly speaking, it is not within the power of clinicians to heal someone else's injuries. In principle, only the injured individuals themselves can heal their own wounds. However, professional assistance can be a crucial ingredient to their recovery. Clinicians can serve

1 Healing means to 'make whole' and thus clearly relates to health. The word 'health' can be traced back to the old English term *hælτ,* which stood for 'wholeness, a being whole, sound or well.' *Hælτ* in turn can be traced to the Proto-Germanic '*hailitho*' and to the Proto-Indo-European *kailo-,* which means 'whole, uninjured, of good omen.' Old English also has *hælan* for 'to heal.' In Middle English health meant physical health as well as 'prosperity, happiness, welfare, preservation, and safety.' When I use the terms healing, health, and wholeness, I intend each of these meanings.

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as effective coaches inasmuch as they understand chronic trauma, know the do's and don'ts of trauma therapy, and possess the required clinical skills.

Ignorance, Fragility, and Control versus Realization

To fulfill their coaching role, clinicians also need professional, societal, and financial contexts that allow them to contribute to the recovery of traumatized individuals. Yet such environmental criteria are not easily met. One major obstacle is that society as well as psychology and psychiatry are not eager to invest in the prevention, education, treatment, and study of chronic traumatization and dissociation. History testifies to this (see Volume I and Chapter 20 of this series; Nijenhuis, 2015a, 2015b). Many families in which emotional, physical, and sexual horrors have occurred prefer denial to realization. Per definitionem perpetrators disregard their victims' interests. The common social pattern is to *ignore* the involved children's *fragility* and pain. Trying to *control* the immense problem of chronic interpersonal traumatization, many individuals and groups turn a blind eye to the outright cruel ways in which a substantial proportion of children are raised. It is a sad fact that many societal echelons prefer to discount rather than acknowledge the suffering of the involved children and the multiple effects of the horrors they are forced to live with. Most peoples, families, and perpetrators as well as mainstream psychology and psychiatry pay little heed to the effects on the health and welfare of abused, maltreated, and neglected children. There are, of course, many fine exceptions. But exceptions are not the rule.

Dramatic cases may serve to disrupt the sweet personal and societal ignorance, at least for some time. Individuals, families, and communities are bound to feel pained and fragile when the reality of chronic childhood traumatization strikes home. Emotionally affected in one way or another, they start engaging in more active ways of controlling the painful situation. Some blame others for failing to serve the best interests of the child. Others disbelieve or discredit the facts of the traumatization. Perpetrators bluntly deny even undeniable facts – or counterattack victims who won't be silenced anymore. Psychology and psychiatry slowly awake from their trauma-ignoring and trauma-ignorant swoon. Society cries out. But when the storm that some dramatic case stirs is over, and when the news of the day leads people's minds in different directions, the soothing veil of ignorance is spread once more.

Ignoring realities is a simple way to control them. Almost by definition it involves only a low to modest level of consciousness. Domineering others is an equally shortsighted means of controlling the complexities of one's world, including one's own fragility. Ignorance and totalitarian attitudes, however, come at a major price: The direct and indirect emotional and economic costs of chronic childhood traumatization are *huge*. The challenge, then, is to realize that this traumatization constitutes a major personal, familial, clinical, and societal problem that defies simple solutions.

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Becoming aware of chronic childhood traumatization is a difficult action. Acting responsibly on the basis of this knowledge is even harder. This realization means enduring high levels of consciousness, intense communication, coordination, and cooperation. It demands a major desire to act as well as a major power of action. It also takes a lot of courage since full realization of chronic childhood traumatization means *taking lasting complex action*. Serious consideration of the existence and high prevalence of chronic childhood abuse, maltreatment and neglect means personally and socially rethinking how every child can be raised in safety. It means being open to a critical analysis and perhaps even a creative reformulation of some basic social structures. This examination necessarily includes a reconsideration of parent's rights and obligations as well as societal responsibilities regarding every new and every evolving human life (see Volume II, Chapter 20, of this series). These personal, familial, professional, and societal actions demand a lasting high level of consciousness as well as tremendous dedication and courage.

So social action is called for, but how social are we at heart? Our essence is our longing and striving to preserve our own being. We have no clue where the will to persevere in nature including ourselves comes from, but it is there, always and everywhere. Acting from virtue, however, is far more complicated. It takes reason: "*Acting absolutely from virtue is nothing else in us but acting, living, and preserving our being (these three signify the same thing) by the guidance of reason, from the foundation of seeking one's own advantage*" (Spinoza, 1677a, Part IV, Proposition 24). Reason tells us that coordinating our actions with those of other individuals, as well as cooperating and communicating with them, is more useful than ignoring or harming them. Hence, according to Spinoza, it is more useful (within limits) to surrender our natural right (i.e., the longing and striving to preserve our being) for the better sake of all than to only consider our own immediate narrow profits. But acting from reason is difficult. It takes a level of consciousness that far exceeds the interests and scope of the present moment. It takes an ability to contemplate life under what Spinoza calls a species of eternity (i.e., from the perspective of the eternal, the perspective of what seems to be universally and eternally true[2]): "*Whatever the mind understands under a species [aspect, perspective] of eternity, it understands not from the fact that it conceives the body's actual existence, but from the fact that it conceives the body's essence under a species of eternity*" (Spinoza, 1677a, Part V, Proposition 29). Despite appearances, understanding realities under an aspect of eternity is not primarily a cognitive act; it is basically affective in that it concerns a love of nature and a love of understanding nature. This perspective, this level of consciousness and its implied perfection provide us with a better chance of overcoming the bondage by our more primitive affects. The challenge we

2 Thomas Nagel wrote in *The Absurd* (1971, p. 720): "Each of us lives his own life – lives with himself twenty-four hours a day. What else is he supposed to do – live someone else's life? Yet humans have the special capacity to step back and survey themselves, and the lives to which they are committed . . . Without developing the illusion that they are able to escape from their highly specific and idiosyncratic position, they can view it *sub specie aeternitatis* – and the view is at once sobering and comical."

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all face to realize chronic childhood traumatization and its implied hate, then, is to develop a will, dedication, courage and ability to acknowledge its existence, prevalence, and harmful present and future consequences. The challenge is to generate and maintain a deep and lasting understanding that overcoming this traumatization, as difficult as it may be, is inherently useful-and hence good–to all.

The efforts of chronically traumatized individuals to heal as well as the efforts of friends and clinicians to support and guide their recovery demand a steadily high level of consciousness. Inasmuch as the societal frame is geared toward ignorance and domineering control rather than toward realization (i.e., knowing facts and taking heed of the consequences of the facts involved), a clash of interests and levels of consciousness will result. Increasing levels of consciousness in chronically traumatized individuals are prone to encounter motivated low levels of consciousness in perpetrators, their partners in crime as well as in psychology, psychiatry and larger societal structures. In light of Buddha's wisdom that "*[t]he darkest night is ignorance,*" trauma healing seems more than a personal venture: It is also a political action. The more traumatized individuals and their bystanders overcome their own recurring alterations of ignorance, fragility and control, the more pressure builds toward a societal realization and limitation of the classic trinity of trauma. The more these individuals speak out, the less society can proceed with blunt ignorance and vicious control.

Theory: A Navigational Instrument

Assisting chronically traumatized individuals is an inspiring and important clinical work. As any clinician knows, it is also emotionally, practically, and intellectually demanding. For example, what to do when a patient presents with an eating disorder, multiple phobias, major depression, suicidality, self-mutilation, nightmares, amnesias, anesthesias, panic attacks, concentration problems or even occasional loss of consciousness, relational troubles, and other symptoms, too? How do I begin to understand the complexity? What are the various symptoms *of*? Do they perhaps relate to each other – and how? And what if the patient, as is so often the case, is seeking emotional and relational proximity, while at the same time fighting this closeness the very moment it materializes? What to do? Where to start?

Clinicians may further have difficulty coping with their patients' recurrent suicidality and acts of self-mutilation as well as with the intensity of their fear, rage, shame, disgust, neediness, and mistrust of others and themselves alike. They must also navigate their patients' tendency to reenact traumatizing relationships in the framework of the therapeutic relationship. Their patients' projective identifications tend to entail another considerable personal test.

The more clinical realities that pose a challenge, the more practical a good theory becomes. Let there be no misunderstanding: Theories are tools, nothing more and nothing

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less. They can support, but they are no substitute for real life. Like other navigational instruments, they ascertain a traveler's present position, propose a direction, and suggest a particular speed of traveling. They warn about obstacles and suggest detours. Theories are clearly useful inasmuch as one does not know the way. But who needs them when you've become your own effective and efficient guide? Only fools consult navigational systems to find a route they know well. But the harder it is to find one's way, the more convenient and important such a supportive guide becomes.

Yet, users know that navigational systems (or well-meaning advisors) are not flawless. The machines may stubbornly announce nonexistent delays or fail to report real traffic jams. When their software is out of date, 'navis' may in fact not find the best available route. They sometimes suggest a road that is blocked or that does not (or no longer) exist at all.

Like other navigational systems, theories are imperfect tools. No matter how helpful they may be in many regards and in numerous situations, even the best of theories err at least some of the time. They do not replace common sense, and they do not obviate the need for occasional experiments to enrich or modify former formulations. Theory and practice as well as solid received ideas and new experimental findings ideally crossfertilize each other and progress together.

Theories describe and try to explain a part of the world that an individual or a group of individuals experience and know. The formulations do not exist separate from this environment. Rather, one's personal, clinical and scientific theories constitute an inherent part of one's world. They are influenced by and in turn influence one's experiences and actions. Moreover, patients tend to have ideas of their own regarding the causes of their troubles and any possible routes to recovery.

A Player and a Coach: Two Organism-Environment Systems Enacting a Common World

Overall, the *Trinity of Trauma* presents a particular understanding of trauma and the practice of trauma treatment. This, the third volume describes enactive trauma therapy both theoretically and practically. Enactive trauma therapy does not involve a strict protocol or set of protocols. It does not prescribe a fixed set of interventions that can be used in a cookbook fashion. Nor does it provide more or less authoritarian recipes or manuals. Rather, the goal is to offer and illustrate an approach to trauma therapy which is broadly applicable and which deeply respects and values autonomy of traumatized individuals and their natural capacity for self-organization.

In enactive trauma therapy, patients are encountered and conceived of as individuals who wish to enhance their power of action, their power of healing a major injury that has life inflicted and that only they can heal with consistent support and coaching from others. Trained in psychology, psychiatry, and psychotherapy, trauma clinicians are seen as

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professionals who can serve as coaches to traumatized individuals. Inasmuch as they have been traumatized themselves, they have developed and executed the actions required to resolve their injuries and pain sufficiently in order to fulfill this task.

As coaches, enactive trauma clinicians do not dictate to the patient what the treatment entails. Instead, they flexibly meet their patients 'where they are' at any given point in time. From 'there,' they invite and encourage patients to engage in new viable and creative actions. These actions are the ones that their patients desire to develop or improve, that are within their reach, and that constitute steps on the way to recovery – on the path to wholeness.

This 'whole' constitutes a new organization. Some patients have never existed as a phenomenal whole prior to successful treatment of their dissociative condition. Some have been operating in a dissociative fashion for as long as they can remember. And the full recovery of individuals who existed as a phenomenal whole prior to the traumatization does not comprise a reinstitution of this unity. Life is dynamic. Everything that exists is in constant motion. In this sense there is no former phenomenal whole there to be reinstituted. Mending a dissociative disorder is not like pasting the pieces of a broken cup back together.

To reiterate, one of the basic insights of enactive trauma therapy is that clinicians or clinical interventions do not in fact cause a change in patients. As self-organizing systems, only patients themselves can effect change. This does not mean that patients and other individuals exist apart from the rest of the world. On the contrary, like any organism, patients comprise an inherent part of their immediate world. In this sense they are necessarily organism-environment systems (Järvilehto, 1998a, 1998b, 1999**a**, 2000a, 2000b). Clinicians are clearly also organism-environment systems. This common feature allows patients and clinicians, at least in principle, to form a common environment. The vehicle of change, then, is the *encounter* between the patient and the clinician. Engaging in an ongoing dance of coordination, cooperation, and communication, patients and clinicians can create a common environment that, in the sense of Gibson (1977, 1979), *affords* change. This enacted common environment or *umwelt* allows the patient and the clinician to strive for a common result: an increase in the patient's power of action to overcome his or her trauma, and, thereby, to enhance his or her ability to engage in new and useful actions.

Like any living organism, traumatized individuals primarily strive to persevere in their existence. Any form of life constitutes an operationally autonomous, primordially affective, and goal-oriented system. Such systems can be stimulated to reorganize themselves when existing actions are or have become useless or harmful. In the service of self-reorganization, enactive trauma clinicians sometimes challenge the unduly fixed action patterns that maintain or even worsen the patient's problems. In order to create something new, it can be helpful, if not necessary, to destabilize the old, albeit not too much but just enough. This challenge is metaphorically referred to as 'throwing a little sand in a well-oiled pathology machine.' As Milton Erickson powerfully put it, "enlightenment is always preceded by confusion" and "until you are willing to be confused about what you already know, what you know will never grow bigger, better, or more useful[3]." In this sense, "change will lead to insight far more often than insight will lead to change." These apho-

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risms beautifully express that in many cases benign, well-timed, and well-dosed experiential destabilization prompts individuals to reorganize themselves more than rational understanding[4].

Rather than prescribe them, enactive trauma clinicians more generally *propose*, *invite,* and *encourage* new actions. To repeat, individuals who have been deeply and recurrently hurt by domineering others are sick and tired of authoritarian instructions. Gentle enactive therapeutic stimulation does not come out of the blue, but rather generally follows small steps of attunement and consensus building. To refurbish an interior design, one needs to first secure access to the house.

One of the most desirable side effects of the therapeutic collaboration is that it tends to increase the clinician's power of action. Clinicians can acquaint themselves with theories of therapy and therapeutic techniques through books, including books such as the present work, that offer transcripts of therapy sessions. They can learn from videos of therapy sessions and from taking part in therapy sessions. This is all true, but there is no substitute for their learning by doing, for working directly with patients, for struggling with complex therapeutic challenges, for discovering new terrain. In order to increase your power of action, you have to seek out your limits and push yourself beyond. One does not learn to climb a mountain by staying in the valley.

The Trinity of Trauma and The Haunted Self

The understanding and practice that *The Trinity of Trauma* presents does not intend to replace the theory of structural dissociation and the phase-oriented treatment described in *The Haunted Self* (Van der Hart, Nijenhuis, & Steele, 2006). On the contrary, the theories and practices involved belong together and complement each other: I experience and regard them as a unity. For example, *The Haunted Self* and *The Trinity of Trauma* both present action psychologies that are related and largely compatible, and both comprise a phase-oriented approach to trauma treatment.

Whereas *The Haunted Self* embraces many Janetian ideas, the present trilogy was, among many things, inspired by contemporary enactivism and by Spinoza's work, which constitutes an early and powerful form of enactivism. While writing Volume I and II, I

3 The reverse, however, does not work. That is, confusion may not lead to enlightenment, but cause a decomposition. Extremely adverse events tend to destabilize living systems as well as provoke a new organization. Dissociation of the personality can be understood in this sense. It follows a decomposition of the personality and comprises a new viable composition of this living system. Enactive trauma therapy is the recomposition of a trauma-related composition that has lost its viability.

4 In my experience, this principle commonly also applies to clinicians who wish to develop new skills and understanding. I have often noticed this mild destabilization and creative reorganization in classes, and I have experienced it myself. For example, I started to learn about trauma and dissociative disorders following mild experiential shocks of my own; see Chapter 30.

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concentrated on Spinoza's contributions in his *Ethics* Part I (*Of God*) and *Ethics* Part II (*Of the Mind*). At the time I had not expected that the present Volume III would become to be written partly in the spirit of *Ethics* Part III (*Of the Affects*), *Ethics* Part IV (*Of Human Bondage*), and *Ethics* Part V (*Of Human Freedom*). However, while reviewing the drafts of the first chapters of the present volume and searching for a deeper understanding of trauma and trauma treatment, I read and reread these three last parts. Grasping Spinoza's dense language and depth of thought was most rewarding, albeit not always easily achieved. The venture was not a goal in itself, let alone a romantic flight in history. Rather, it was guided by the growing realization how wisely *Ethics* speaks to human confusion, conflicts, and trauma–as well as to a possible liberation from human bondage by passions. The endeavor was also compelled by a growing insight into how several 'new' and contemporary psychological insights, theories, and approaches to treatment strongly appear to be Spinoza's original thoughts in disguise. Honor to whom honor is due.

Enactivism emphasizes that in order to experience and know themselves, other selves, and the material world, individuals must *act*. They must *do* something. Enactivism essentially proposes that *organisms bring forth a self in action as well as a world and the relationship of this self and this world.* It holds that 'subjects' and their 'objects' (including other 'subjects') constitute and depend on each other, and that they always occur together (Järvilehto, 1998a, 1998b, 1999a, 2000a; Northoff, 2003, 2014a, 2014b; Schopenhauer, 1819, 1844; Spinoza, 1677a). That is, there is an *intrinsic* relationship between subjects and their perceived and conceived material and social world (or *umwelt*). Practically speaking, no world exists without an experiencing and knowing subject, just as all subjects exist, mature, and develop in virtue of a material and social *umwelt*. Subjects and their material and social objects exist in virtue of their coupling. They exist and can only be known relative to each other.

It is, however, quite common in psychology and psychiatry to regard and treat organisms and the world they experience and know as two separate systems. For example, by assuming that individuals and their environment constitute two systems, many neuroscientists look for normal and abnormal consciousness in the brain. In this sense, trauma means there is something wrong 'in' the individual. *The Trinity of Trauma*, however, rejects the dissociation of organisms and their environment. I understand trauma to be a feature of an *organism-environment system*.

Traumatized individuals are host to more than one conception of who they are and what the world is like, and how they relate to this experienced and conceived world. Confronted with a violating reality, their personality as a whole organism-environment system has become divided into two or more dissociative organism-environment subsystems or parts. As each dissociative part they enact, that is, they bring forth in action a particular phenomenal self, a particular phenomenal *umwelt,* and a particular set of relationships between this self and umwelt. For example, some dissociative parts mainly bring forth a phenomenal self that experiences a traumatizing *umwelt* without realizing that this self and this *umwelt* in fact belong to past realities. Traumatologists describe this constellation of actions as a reenactment of traumatic experiences and a reenactment of traumatic re-

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lationships. Other dissociative parts in turn enact a phenomenal self that does not or not sufficiently integrate and realize this traumatized phenomenal self and this traumatic phenomenal *umwelt*.

The Haunted Self and *The Trinity of Trauma* are more generally attempts to integrate particular insights stemming from, among others, learning theory, including classical, operant, and evaluative conditioning, dynamic systems theory (Thelen & Smith, 1994), attachment theories (Bowlby, 1969, 1973, 1980; Fonagy, Gergely, Jurist, & Target, 2002; Liotti, 1999, 2004, 2006), and affective neuroscience (Panksepp, 1998; Panksepp & Biven, 2012). The two works also integrate ideas on transference and countertransference (Dalenberg, 2000), particularly but not exclusively with regards to interpersonal reenactments of traumatizing relationships.

Accepting and integrating components of these various theories does not mean accepting and integrating all of the elements they encompass. Nor does it necessarily imply adherence to the background (i.e., the philosophical) assumptions that drive these models. As detailed in Volumes I and II, and as also discussed in the present volume, *The Trinity of Trauma* rejects philosophical dualism, materialism, epiphenomenalism, realism, and representationalism. For example, it assumes that matter and mind are two properties of one system that may include many more properties (that we are not aware of) (Spinoza, 1677a). The brain/body and the mind are thus not regarded and treated as different substances or systems. And they are not seen as causes. For example, the brain is not seen to cause the mind, and the mind is not considered the cause of its objects. Mind and matter are rather conceived of as different attributes, properties, or appearances of one system: nature.

Like *The Haunted Self, The Trinity of Trauma* considers the dissociation of the personality. But, given the above considerations, *The Trinity of Trauma* explicitly regards 'personality' as an intrinsic component of an organism-environment system. Another difference between *The Haunted Self* and *The Trinity of Trauma* is that the present work uses the term controlling emotional parts, whereas *The Haunted Self* prefers the term perpetrator imitating emotional parts. The term controlling emotional parts in my view captures *the goal* or *final cause* for imitating perpetrators in some regards. Any organism strives to control its one's fate as much as possible, and children learn an immense amount by imitating others. As William Wordsworth (1770–1850) observed, every young child goes through a phase in which he or she is "as if his whole vocation were endless imitation" (1807). What else is there for chronically traumatized children to imitate than the negative kinds of control that perpetrators and their accomplices enact? In this light, clinicians are challenged to model positive ways of influencing one's self and one's world.

The Trinity of Trauma: A Trilogy

The current third volume of *The Trinity of Trauma* offers clinicians, to use a Beatles phrase, a little help to get by[5]. It builds on Volumes I and II, which provide, define, and

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ground basic concepts. These include trauma, event, traumatizing event, traumatic event, traumatic experience, dissociation, personality as major features of an organism-environment system, dissociative subsystems or parts of the personality, and more. As mentioned above, the formulations are grounded in a monistic philosophical framework that strives to avoid and overcome the major problems of philosophical dualism, idealism, materialism, and realism. Volumes I and II also present empirical findings, including the results of functional and structural biopsychosocial research of trauma-related dissociation of the personality.

The opening theoretical chapters of the present volume look at enactivism and enactive trauma therapy. The practical chapters describe how the philosophical, conceptual, and theoretical formulations and empirical insights can assist clinicians in their practical work with chronically traumatized individuals. Whereas in some respects the trilogy begins at a rather abstract level of analysis, it culminates in transcripts of actual therapy sessions. These records are complemented with my technical and personal comments and, in two cases, with posthoc comments from the involved patient. The comments are not meant to be exhaustive, which would only serve to exhaust the reader. Rather, they illustrate some of the major feelings, thoughts, and dynamics regarding both the patient's and the clinician's efforts to achieve a common result: the healing of the patient.

The *Trinity of Trauma* addresses several aspects of the philosophy of mind. Any psychological theory and practice is grounded in philosophical assumptions and reflections regarding mind, matter, and more. It is important to be explicit about this foundation. Volume III thus reiterates some of the philosophical problems discussed in some more detail in Volumes I and II. While overall the *Trinity of Trauma* covers some of the major issues from the philosophy of mind, it is not an exhaustive treatise in this regard. An excellent, more complete, and quite accessible account may be found in Northoff's *Minding the Brain* (2014a).

Readers with limited interest in theoretical issues or those with a touch of 'philosophy and theory phobia' may prefer to begin reading with Chapter 30. As they go along, however, they may have the experience that philosophical and theoretical reflections are not completely irrelevant to the practice of psychotraumatology. They may actually detect that these considerations are indispensable.

To emphasize that *The Trinity of Trauma* constitutes a unity, Volume III starts where Volume II left off. The first chapter of the present volume is thus numbered 22. This system serves to invite readers unfamiliar with Volume I and II to explore the preceding texts. Volume III picks up on but does not fully reintroduce the contents of the first two volumes. However, the major, rather complex insights of the prior works are taken up again–and several are elaborated on. A certain redundancy and frequent references to pre-

5 From the song "With a Little Help from my Friends" on the album *Sgt. Pepper's Lonely Hearts Club Band* (1967). George, John, and Paul sing "*What do you see when you turn out the light?*" Ringo answers "*I can't tell you, but I know it's mine.*" This is a good example of how we cannot experience someone else's experiences, but we can empathize with them.

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vious chapters are intended to orient readers who are not or not completely familiar with Volumes I and II.

Clinicians and Therapists

Clinicians need not also be psychotherapists or other therapists. However, like therapists, clinicians who are not also therapists have as their goal to assist and hence affect their patients. Whether and how a clinician or a therapist exerts influence on the patient depends on the actions and passions of both parties. The ambition of the present volume is to inspire the actions of clinicians and therapists alike. It therefore seemed best to generally address the general class (i.e., 'clinicians'), even if, in many instances, the text speaks to therapists more than to clinicians who are not also therapists.

Gratitude

The Trinity of Trauma is a work that stands on the shoulders of many giants. To name a few major inspirations: Aristotle, Baruch Spinoza, Arthur Schopenhauer, Pierre Janet, Charles Myers, Ludwig Wittgenstein, Francisco Varela, Andreas Weber, Evan Thompson, Stephen Braude, Timo Järvilehto, Georg Northoff, Thomas Metzinger, Frank Putnam, Richard Kluft, Onno van der Hart, Giovanni Liotti, Bessel van der Kolk, and more. I am also indebted to several colleagues who attended my classes and to other colleagues who thought along with me. To keep the list short, I shall restrict myself to expressly naming only Arne Blindheim, Raimund Dörr, Peter Heinz, Gabriele Heyers, Hanne Hummel, Astrid Lampe, Isabel Lopez-Fiestas, Sebastian Lorenz, Winja Lutz, Andrew Moskowitz, Olivier Piedfort-Marin, Julia Michel, Henk Otten, Siegfried Rathner, Thomas Renz, Stella Sadowsky, Harald Schickedanz, Manfred Stelzig, Steinar Svoren, Ingrid Wild-Lüffe, Dominik Schönborn, Rainer Schwing, Sander van Straten, Fabian Wilmers, and Eva Zimmermann. I am indebted to all of them. Timo Järvilehto's comments on a previous version of the present text were most helpful, as were our continuing discussions. Highly appreciated, Timo, there is so much to learn from you! Peter Ward brought several most worthwhile papers to my attention. Much appreciated, Peter! I am no less grateful to the many helpful colleagues whose names are not mentioned here. Joe Smith, your linguistic corrections and other editing have been vital. My sincere thanks go to you.

No matter how much I learned from historical heroes, contemporary masters, and acquainted colleagues, *The Trinity of Trauma* primarily rests on the many encounters with the many traumatized individuals who were willing to engage in a therapeutic dance with me. A few of them appear in this book. It is an exceptional privilege that they allowed me to use their therapy sessions verbatim along with more general descriptions of their personality and painful history. 'Ineke' and 'Sonja' deserve a very special place among them.

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They were willing to watch and comment on the videos of therapy sessions contained verbatim in this volume. As mentioned above, their comments on *what it was like for them* to be in these sessions are also included in the present volume. Their courage provides readers with intimate access to the first-person and quasi-second perspectives of these traumatized but now fully healed individuals as well as to their second-person perspective regarding me as their former coach. In closing, I express my deep gratitude to my near family members for their continuing love, support, and understanding, especially the straightforward honesty of children: Our eldest grandchild, Asia, told her mother that it was better to return the first two volumes of *The Trinity* to granddad. Moving to a new home, she was concerned that such a heavy book without any pictures would overload their car.

We are all organism-environment systems. No one exists, feels, thinks, and moves in solitude. Blossoming is infinitely easier in a benign, sympathetic, and loving *umwelt*.

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Introduction

Volume III in Brief

> *The striving by which each thing strives to persevere in its being is nothing but the actual essence of the thing.*
> Baruch Spinoza (1677a, Part III, Proposition 7)

> *. . . the decisions of the mind are nothing but the appetites themselves, which therefore vary as the disposition of the body varies. For each governs everything from his affects; those who are torn by contrary affects do not know what they want, and those who are not moved by any affect are very easily driven here and there.*
> Baruch Spinoza (1677a, p. 73)

In order to orient readers to what is to come, I would first like to present an overview of the structure and contents of this text. It starts with a number of theoretical chapters and continues with eight practical chapters.

Theoretical Basis

The problems of trauma and dissociation are largely problems of consciousness and self-consciousness. The initial Chapter 22 is therefore concerned with self-consciousness and world-consciousness in general as well as in trauma and enactive trauma therapy. In Chapter 12 of *The Trinity of Trauma* (hereinafter referred to as ToT), it was stated that self-consciousness, our 'I,' involves our phenomenal conception of self (for a clarification of the term 'phenomenal,' see below). Generated in our ongoing action, it tells us who we are. As Metzinger (2003, p. 1) put it, a phenomenal conception of self is "a wonderfully efficient two-way window that allows an organism to conceive of itself as a whole, and thereby to causally interact with its inner and external environment in an entirely new, integrated, and intelligent manner." This self, the inner world, and the external world are not pregiven but involve our phenomenal conception of them.

Chapter 22 provides an additional perspective to the effect that (self-)consciousness evolved as an efficient means of supporting relationships between individuals (Järvilehto, 2000b). Simple relational forms demand little coordination, cooperation, and communication, whereas the more complex the tasks organisms face, the more they are challenged to coordinate their actions – and to cooperate and communicate with each another. In-

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