Rich: Welcome. My name is Rich Simon. I'm editor of *Psychotherapy Networker* and I'm host for this event, which is part of our State of the Art 2013 virtual conference. In this State of the Art, we're trying to do something we usually don't have an opportunity to do, which is to take a step back to really survey the latest advances in the major areas of practice within our field. To invite in the most productive innovators in these various areas of practice. To look at clinical advances, interesting research findings. To identify important issues and debates within each of these areas of practice. And today, our focus is the area of trauma treatment. So over the last 30 years – 30 years ago when I was in graduate school, the word trauma was a problem that dare not speak its name.

There was – I can't remember a discussion of trauma in my early clinical training. And as we all know, that changed very radically beginning in the '80s, beginning with DSM-3, and the inclusion of the PTSD diagnosis as a result of some political struggles of Viet Nam vets at that time. Since then, this has been one of those areas of practice that's probably changed most of any area of clinical practice over these last 30 years. And what we're going to be doing today is looking at that 30-year developmental progress of our notions about trauma. Some of the pendulum swings within that area of practice. Some of the issues, some of the debates. And we have with us two innovators in the field of trauma treatment who have been involved through that entire period.

We have – one of whom is Mary Jo Barrett, who is the director of the Center for Contextual Change and who is really focused very much on interpersonal violence and childhood sexual abuse, amongst other aspects of trauma during that time. And along with Mary Jo we have Dick Schwartz, developer of the Internal Family Systems Model, who has done all really specialized work of trauma across the range of what might be defined as traumatic presenting issues. And I want to welcome the two of you here today.

Mary Jo: Hi, Rich. Hi, Dick.

Dick: Hi, Mary Jo.

Rich: This is a conference for practitioners. The whole point of the State of the Art conference is really to help people get up to date on what advances in treatment are, what are the practical nuts and bolts issues of practice and the challenges, what are some possibilities

that they might want to explore in their practices. So let's start off with this question that increasingly is something that I find confusing; I think many practitioners do. As this term becomes more and more popular in contrast to its state 30 years ago in the pre-DSM-3 era, which is the term trauma. We use trauma to refer to a whole range of things. And often, I'm afraid, we misuse it. Let's start off. I'd like to hear from each of you: what's your notion? What constitutes trauma? What do we mean in the psychotherapeutic context by someone has experienced a psychological trauma? Mary Jo, you want to get us started?

Mary Jo: For me, defining trauma – as you said, my beginnings and pretty much what I've stayed consistent with is the issue of interpersonal boundary violations: physical, sexual, emotional, spiritual boundary violations. And the way I've defined it – and I've gotten my definition from my clients, basically – which is that trauma is an interruption in their life. In the context of day to day life, child development, family development, even the flow of your day to day life where something happens that interrupts what you would expect to have happen. So that it's an event.

Trauma is really a traumatic event that interrupts what you would expect to have happen in that context of that context of the relationship, the context of work, or even if we look at the violence of you're at a mall in Nairobi shopping, and the traumatic event is the murders that are happening which you didn't expect when you went shopping. So what happens is you are in your life and a violent – that's what it is for me – a violent boundary crossing, a violation interruption of what would be the normal course of your flow of direction in life and relationship and development. So to me, it's a traumatic event.

Rich: Let me just put a somewhat finer point on that. Because we all know that in that shopping mall in Nairobi, all the epidemiological research or clinical experience tells us that something, a horrible event happened. That in a loose sense, what a traumatic thing to happen. If we actually look at the response to all the folks that were exposed to that, some people will be traumatized by that. Their day to day functioning is going to be very radically changed because they happened to be in the wrong place at the wrong time. And most people – and this is that finding about kind of the inherent resilience in most people – most people will not experience that – at least on a permanent basis.

They may be distressed and upset, but on-goingly, they will not be traumatized by what happened, even as almost unimaginable violence at that scale may be for many of us. So how does that fit with this definition? How do we put a finer point on our notion about when someone comes in that we don't immediately assign them the identity of a traumatized client?

Mary Jo: So let me – and then Dick, I want to hear what you have to say – to me, what you just said, Rich, defines the difference between PTSD and complex trauma. That there will be a group of people who will have post-traumatic stress disorder from this event, if we're just going to look at Nairobi. Or you can look at it across the board. When I worked with Vietnam vets, the vets that came back with – there were vets that came back with PTSD and there were vets that came back with an entire different groupings of symptoms. And PTSD is when a life injurious event happens. And often the symptoms of PTSD last somewhere between six months to a year.

Where in complex trauma – and so to put it the most simply; it's what did they go into that day of shopping with? If they went into that day of shopping with – coming from complex trauma, meaning being abused at home, being abused as a child, being abused, violated in couple relationships, having a history of child sexual abuse or neglect, or other violations; their reaction to that traumatic violence is going to be different than the person that comes in without a history. So complex trauma, which is what most of your audience is going to be treating, is people who, over their developmental stage, had reoccurring violations in the context of a relationship.

And to me, what's really important is also the response of the context. So you're violated by someone in your family and then how do other people in your context now – including therapists – respond to those kind of violations. That's complex trauma.

Rich: We'll get back to that. Dick, how do you weigh in, here, about understanding the notion of trauma? Is there this fundamental – are there two kinds of categories – primary categories – of trauma as Mary Jo is laying it out? What's your take on that?

Dick: I agree with what Mary Jo just said. For me, trauma, per se, isn't traumatizing. So what's traumatizing is the effect on both the internal system of the person and the external system and the degree to which an event forces a person to split off parts of them

that are now frozen in that time when it happened and have other parts of them try to lock all that away and exile it, and then run their lives in such a way as to try and keep anything like that from every happening again. So that's some of the impact that trauma has on an internal system. And you'll find in families or groups of various kinds a similar kind of rigidifying and locking away. And it might not be a group of people, but it might just be belief systems become much more rigid as a result.

And a lot of it, as Mary Jo said, does depend on the level of exiling that's already occurred in the person's life and if this event then triggers all of that and brings it back in an overwhelming way so that the person can't cope with the Nairobi thing, then they'll walk away with much more of a traumatizing effect. And also what she said about the context is very important. Because if someone gets really scared or hurt, and the people around that person encourage them to be with the pain of it or be with the fear and to not lock it up, and to actually – then that can actually be unloaded. That can be let go of in such a way as to minimize the effects – long term effects – of the trauma. So anyway, some of my thoughts.

Rich: Okay. This distinction, here. Is there, in some fundamental way – both of you are trauma specialists. You certainly see clients who are not trauma clients and without being subject to some definition or let's more carefully define that. Is there – what's the difference in the kind of work that each of you do when you're working with the worried well, you're working with someone who's anxious, you're working with somebody who's depressed, and you're working with somebody who – by your definition – has been traumatized? Mary Jo?

Mary Jo: That's a really good question. I want to hear what Dick says, first. But it would be interesting. Because I think probably both of us might say similar things. I don't know that I approach it all that differently. Now, part of it I would say to you I don't see a lot of people. Not because I think trauma's behind – complex trauma's behind every client or every symptom or every tree. But that's who gets referred to me and to the center. That's our specialty. However, because I follow a very – as does Dick, I don't know that I do it very differently – is that part of my emphasis is two things. One is I can't ever know if anybody has complex trauma

So if a couple comes in, I'm not going to assume that there's violence, but I also know that people aren't going to always come

in reporting childhood sexual abuse, incest, domestic violence. They're not going to report it. So on one level, I have to create a context where that if there is violence or interpersonal trauma in their history, that they're going to be able to talk about it. So I think on one level, when someone comes in I approach it as have I created a refuge? Have I created a collaboration so that we are really working together on what's going to be the most helpful to them. And that's across the board no matter what the symptom is.

So if it ends up being that their symptoms are a result, or part of – as Dick said – times in their life where they have frozen, cut things off, or learned how to respond to stress; that's part of what happens. When you have complex trauma, you respond to the world as if there's danger. That's what we mean by hyper arousal. That there's danger even though danger might not really exist. And so I have to – when I start off with anybody – create an atmosphere so that they can tell me what it is they need to change and how they're going to go about doing it. And on that level, it doesn't matter if it's complex trauma or not.

Rich: Dick, why don't you weigh in, here. And let's stay with here for a bit because it seems like there's a fair amount to discuss. Is this distinction between people coming in with what I'm casually – maybe cavalierly – describing as more garden variety human suffering and traumatic suffering; is that an important distinction for you, not so much mentally but in what you find yourself – how you find yourself responding to a client?

Dick: My experience is that there are many so-called garden variety neurotic clients that as you start to peel away the layers and do this internal work that I do, you find that most of us have parts that are frozen somewhere. And it could be attachment injuries from parenting or humiliations from elementary school. But most of us have parts of us that we left in the dust because they carry these emotions, memories, sensations, and beliefs that we never want to experience again. And so I don't make a big distinction between this is a traumatized client and this isn't. I work with people that have a lot of obvious trauma symptoms, and those people don't necessarily have more trauma.

It's just that their what I call manager parts of them weren't able to contain it as well. And so it leaks out a lot more in their lives and is more obvious. So they get more severe classifications. But I've worked with lots of CEOs, for example, who, to everybody around

them, seemed totally together and capable and on top of it. But it turns out to be this striving part of them that said: I'm never going to feel that way again. I'm just going to work my ass off until I'm totally in power and succeed over everybody else. And they've got a huge trauma history in there. So I'm doing this work and we find out what's in there. And most of the time, there is what I call exiles that need to be healed.

Rich: One distinction – and let me get back to whatever point you're about to make, Mary Jo – but it just occurs to me one way to focus this a little bit is that there is one current in psychotherapy that is encouraging us, for a number of reasons, to see ourselves more as coaches. We serve an educational function in the lives of our clients. We teach them skills, we help them take a step back from their difficulties, we go on the sidelines with them. We send in plays, they try it out, we give them feedback. And that's one current. And then there's a current that we're talking about here, about reparative relationship. About a difficulty of people who cannot make, at least initially, take advantage of this more coaching relationship that assumes a certain level of being able to respond to feedback, to translate a more cognitive discussion of your difficulties in life into an action plan and then carry it out.

Is that part of this distinction, what we're talking about, at an intuitive level when you're talking with someone who's experienced complex trauma in their life? You begin to feel, early in the relationship: oh, okay, this is a different territory. This is going to be a multi-dimensional relationship. In some way, something else is going to be different – is going to be required of me, here, than – again, cavalierly I'm referring to as somebody who is more of a coaching client or more towards the coaching end of the psychotherapy spectrum. Does that make any sense for you, Mary Jo?

Mary Jo: Yeah, it makes a lot of sense. There's so many things that we could talk about, here, just based on what you said. I can't even remember the point I was going to make so we'll let that go.

Rich: All right, well, I'm sure we'll come back there.

Mary Jo: Except maybe the point is that – see, this is why it's so difficult. Because we really didn't even define trauma because it's really hard to define it. And then labeling things trauma, it's so – because I would disagree with what you said in that I think there are some

extremely, extremely traumatized people who, in fact, when they start off in psychotherapy, all they can tolerate is skills. So that that coaching – I'm just thinking of a family I saw last night where there's an incredible amount of trauma. Sibling incest, both parents being abused, kids self-mutilating, eating disorder; all in this family. And basically, because of all those levels, all they could tolerate right now at the beginning of therapy is skills about parenting. How to respond to their child.

So that going in and starting to talk about their history or look – eventually, I will probably – I know I will – talk to the parents about doing individual. Probably even refer them to an IFS therapist. But the point is, I think we can't make that decision of if you have complex trauma, you can't handle skills, yet. The timing of the intervention is a collaborative decision, not just based on my gut but based on the need of the client at the time. Some people really will respond much easier with a body orientation to begin with versus a skills, a cognitive. They just need to be able to breathe and get grounded. And some people, it would be more of a cognitive approach.

So again, that goes back to saying you can't have a predetermined: this is how I handle my worried well, this is how I handle my trauma. It's: this is how we handle human beings. Just like what Dick said. And then, the layers of their trauma – or their layers, is it just traumatic stress or is it complex trauma? That will unfold.

Rich: Yes. Let's make some distinctions, here, and then you'll get in on this one, Dick. In your response, therapy is about people and we're making some broad categorical distinctions here, to kind of tease out some kind of conceptual clarity in our conversation. In your response to this idea of coaching versus trauma, clearly, intuitively, you're saying two things. One: therapy has stages. You join with people, where they are. You can't predict where you're going to be later in the process. But there's something in you, as you sat with this family, let's call them troubled family and you knew something of their history that said to you: okay, I have to make it really safe early on and it's going to be more coaching or psycho educational.

And this may change later on, and you have a sense that if we're really going to get into our work with each other, we're going to have to deal with some of that. As opposed to some of our colleagues who just see a clientele where it's exclusively a kind of

chatty, coaching, more kind of let's take a bird's eye view of your life. And, perhaps with occasional intensity, we'll get into some emotional issues. But our relationship with each other is not going to be terribly complex. That is, between – at any stage of psychotherapy, and that defines a certain part of the therapeutic spectrum. Do you have some thoughts about that, Dick? Do you see people where you don't feel like you – even though your specialty is trauma and you're Mr. IFS and this is your particular area of skill – where you don't. It doesn't get that complicated. You're not dealing with a lot of different parts in the therapeutic relationship unless it's required of you as a result.

Dick: You probably already know the way I'm going to answer that question, which is –

[Crosstalk]

Rich: America is waiting for your answer.

Dick: No, I don't. But I can piggyback on what Mary Jo said, a little bit. So I really like to get in there and heal some of this trauma. But there are many clients where you can't do that for quite some time, for various reasons. One of which is their external context is constantly bombarding them and they don't feel enough safety because of their family or because of their job to actually have the space to be vulnerable, to go to these vulnerable places and actually do that healing. So I'm still a family therapist. I'll still survey the external context and, if necessary, if you want to call it coaching, you can. I don't necessarily see it that way.

But do family therapy in a more directed way, or more a collaborative brainstorming in that how are we going to create the space where you can actually show vulnerability in your outside world at times and not be bombarded and not have people attack you for it. I developed this model at the Institute for Juvenile Research where I met Mary Jo. And working with kids in the streets of Chicago who would come in and say: if I ever show vulnerability on the street, I'll be killed.

Rich: That's exactly in those terms that's the Institute –

[Crosstalk]

Dick: Not exactly in those terms. But doing this kind of vulnerable work was a tough sell. And we had to do lots of negotiating about how

this very tough part of them could stay in the street but maybe could drop its weapons in my office. So I'll do assessing both of how much space is there in the sense of how much can the people around them allow for them to be at all vulnerable. And also, are there things – like Mary Jo's been talking about – happening in their context that are constantly triggering them. And if that's true, it isn't the best time to actually do this deep work. And so we'll spend time trying to change that. Or we'll spend time strategizing: if I can't change that, how to navigate around it so that we can do the work and often it just takes a lot longer because the safety is such an important issue.

Mary Jo: I want to say something. Because in a way taking – it's a little political, but what Dick said, I think we need to emphasize. Talk about intuitive, I mean this is a gut reaction. In that both Dick and I started together in Chicago with working with families and people who were incredibly disenfranchised, experiencing violence. This wasn't a middle class, upper middle class understanding of treatment. And I think that's really important because often so much, we have to talk about what kind of services we're providing to the people who aren't coming to private practices or who aren't coming into the offices to get trauma treatment. That's, I think, the other piece.

Is that when we think about trauma, we have to also keep in mind the therapy we're doing has to make sense to people who are every single day experiencing trauma and violence in their families and in their community. Not only does it have to be effective, but it has to make sense to the clients. And I think that's something we can't forget. Is that our jails are filled with people who have suffered from complex trauma. Drug abuse, robbery, committing violence on other people is a symptomology of complex trauma. And so I think we also have to keep in mind what are we doing in the field when we're talking about trauma for when it's actually happening in families, currently.

How are we intervening? How are we making sense? How are we providing services? The broad spectrum. And particularly when it's actually happening in the families. Not just adult stuff.

Rich: This is not a point of emphasis in our field at the moment in the way it was in the more of the family therapy heyday. So this idea of one of the things you have talked about, Mary Jo, and other conversations have. We have a euphemism that trauma, as intense

a word as it is, it's a euphemistic term referring to a certain kind of interpersonal violence that is behind why lots of people come in to psychotherapy and that's the trauma that they're coming there for. You want to say what you mean by that?

Mary Jo: More than what I just said?

Rich: I think what you're just saying was about kind of the larger picture of this is what's happening in society. But an understanding of when you're sitting in the room with people and they're, quote, traumatized. But what you're dealing with is something closer to something that makes us uncomfortable when we – we don't want to be in a car accident or in a shopping mall in Nairobi, but the idea that we're sitting with a client who's been sexually abused by a parent, for example, is something that, for many of us, strikes closer to home. That's a more difficult reality to deal with.

Mary Jo: Right. And I think that the piece – one of the things that I've seen, the emphasis in the field, is that we're focusing much more on people who – that the treatment that people are studying or writing about is really for what we – adult survivors. And one of my concerns is, as clinicians do we really understand and what are we doing and what are our treatment models for when the trauma, the complex trauma that Dick and I see all the time, is actually happening? So when the person you're working with is abusing their child. Not only are they –

Rich: In the present. We're not talking about trauma as a past event, okay?

Mary Jo: Right. And that it's probably part of their complex trauma. That it was a past event but they're currently in relationships where there's violence and violation. They are committing the violation. For example, sibling incest is the most common form of incest. And it is still happening on a very – it's still happening, frequently. And it is the most common. And we haven't seen it happening less. And yet, I don't know if trauma therapists feel equipped or are studying on how to handle sibling incest when it's currently happening. So that's part of my concern about the field.

Is that now, trauma sort of has this euphemistic of equivalent to adult survivors. I'm a trauma specialist. So it's sort of these two extremes. Either I'm a trauma specialist when it's a violent event like as a terrorist attack or a hurricane or a tsunami; that kind of

trauma specialist that goes out. Or an adult survivor. My question is what is the treatment – what are people's treatment models when it's currently happening?

Rich: You have some thoughts on that, Dick? Is that something that you deal with in your practice, frequently?

Dick: No, I don't work a lot with children. But I work with families that – and I work also with domestic violent couples and so on, where there's actually ongoing kinds of violence. But I know a lot of therapists who do the kind of work Mary Jo does with kids and those kinds of context. There are a lot of IFS therapists who specialize in working with abused kids. So I don't have the same level of nobody's doing it or there aren't models for it that Mary Jo seems to have.

Rich: Let's focus on – we're making some distinctions within this broad, umbrella term of trauma that I think are helpful. And let's identify – we're identifying different kinds of issues, different kinds of questions. Let's, for the moment – so you're – Mary Jo, so you're focusing on this from your background and working with kids and families and ongoing violence not to say that this is exclusively an issue of children, but I think there is a special sensitivity when kids are involved. Let's address for the moment the trauma that someone – it's the past event. We identified trauma earlier as an exposure to life events – sometimes a single occurrence – that is so potent that it takes over your nervous system and it becomes hard or impossible for you to distinguish between being in this state of danger and everyday life.

If that's broadly speaking, this kind of encompassing sense of danger that you live with, it's kind of an impressionistic description, at least, of a certain kind of variety of trauma; what is the biggest mistake, in your view, in terms of this – if this conversation is giving some guidance, practical guidance, to therapists out there from people who have lots of experience in this area – what's the biggest mistake that people make in working with that kind of trauma? Dick, you want to start off with this?

Dick: Okay. So what you just described is what I was addressing earlier, that when there is that kind of traumatic event, there are parts of us that freeze and are locked in time. And they live as if what happened then is still happening. And because that's so distressing to us to have to re-experience, we try our best to get away from

them and to leave them back there. And so the mistake – there are a couple of mistakes people make. One is to try – the people that do a lot of – have reactive kinds of things or cathartic based kinds of work, make the mistake of trying to go to those places as soon as possible. And have the part that's stuck back there fully re-experience, or make the person fully re-experience what they went through. Why is that a mistake?

Because sometimes that can be helpful. It's a mistake because many times – even our community has gotten hip to this, too – because that technique can get you there quicker. It can bypass what I call the protective parts of us that don't want us to go there. And when you do that bypass, you might get to that exiled part that's frozen in time. It might have a good experience. And the protective parts you've bypassed will punish the client in what we call backlash kinds of reactions. So they might never come back, or they might regress in some way or another, or they might have nightmares. I've had clients leave my office when I didn't know what I was doing and I was doing that and immediately get a 104 fever or get in a car accident on the way home. Literally, those things happened.

So at some point, I realized before we go to those places we have to make peace with the parts of clients that don't want us anywhere near that. So when I'm working with those clients, before we go to that raw material, I'll ask to work with any parts of them that are afraid to let us go there or don't trust me to do it, or don't trust me at all. And we'll spend a lot of time getting permission before we go to those exiled parts, then. And then there's a process for healing those parts. And then come back and all these protectors are relieved because they don't have to work so hard to keep all that locked up. So that's one mistake, and I could say some others but I've talked enough.

Rich: Yeah, you said you had two. So let's – and Mary Jo will have her turn in a moment.

Dick: Okay. Well, the mistake on the other side is a sense I get from some trauma models that – this is related to what we were talking about earlier with the stages – that before you go anywhere near any of that stuff, you have to have a person very stable. The stabilization phase where their life is in better shape and they're not being triggered by anything and they have these skills. There's a lot of skill building, skill teaching, breathing skills, grounding

skills; that kind of thing. And that that phase can take a long, long time before people feel safe enough to go to the trauma. Because once you decide to go there, sometimes these exiled parts will take over and the kind of bad things I just described will happen. So that's a mistake at the other end of the continuum, where people have become very gun shy of going to trauma and think that the client has to be basically really well functioning before you put your toe in that water.

Rich: I hear the description of that style of working. And why is that, in your view, a mistake?

Dick: Because it's possible to get there much more quickly if you know a couple things. One is to work with these protected parts that don't want to go there so they don't cause the havoc that they would if you didn't have permission. And second, that there is this thing I call the self that if you can get access to, can go there without the overwhelm. And if you ask permission of what I call the exiles to not overwhelm, they won't. So you don't need nearly the same level of skills and skill building. My basic position is people have all they need to heal. Just like your body, if you cut yourself, knows immediately what to do to heal itself. You're born with that emotionally. And our job is to kind of kick start that. And EMDR does that.

There are some other techniques that actually do that. But there's a very planful way to access this state I'm calling self where people manifest these qualities. And then, in that state, go to these places where they're not so overwhelmed and they can actually get these parts out of where they're stuck in the past. And often, the child-like parts, lift them out of where they're stuck in the past and then unload all the traumatic emotions and beliefs that they've been stuck with all this time.

Rich: That makes sense. So what you're saying it's almost like going back to this idea about coaching. This over-emphasis on coaching on the front end underestimates an inherent resilience that people have in this inherent capacity for healing.

Dick: That's my position, right.

Rich: Okay. Mary Jo, I think there's a lot of overlap in what you might say.

Mary Jo: Yes. Absolutely. I would obviously use different language.

Rich: Okay. You're allowed to overlap. But is there something you might add to what –

Mary Jo: I will add. I'll just add a little bit. One is, I would agree it's about pacing and timing. And I think the biggest mistake that clinicians make is that they don't collaborate with the client to make sense of what's the best pace for that individual client so that they don't really assess what are the client's resources so that they make their decisions just like what Dick said. Those choices of pacing, of how fast, what interventions to use, should be based on the client's vulnerabilities and the client's resources. It shouldn't be based on solely my model or me as the therapist. And so the biggest mistake is this lack of really bringing the client in and saying: how do you best change? How do you best learn? What's been your experience in the past with other therapies?

What's worked for you? What doesn't? How do I make my decisions about my intervention and my timing – again, based on the clients and our collaboration. What are my skills? Which would go into my next biggest mistake is that – just like what Dick said – I think a lot of times, therapists make their decisions based on their own experience and what's happening for them in the room. And so I think that many, many times therapists become afraid. They become – I don't know what I'm doing. They go: I have this model, I must follow this exact model, what I've learned. I've learned these techniques, I've learned these skills; this is what I have to do. So they lose sense of their own vulnerabilities and resources.

And so what happens is, I think in terms of good trauma treatment, the therapist has to be aware of what the client's vulnerabilities and resources are. At the same time, what are my vulnerabilities and my resources? And what's happening between us? What is the dynamic in this room, in this moment, that is triggering me, triggering the client? Have we lost our connection? Is the client with me? So the biggest mistake is the therapist not having an awareness of their own sense of self in the moment.

Rich: So all of that seems clinically wise and a bit general. Do you have an experience, either as a supervisor or as a therapist – preferably a concise one – that kind of captures what you just said? It sounds like that's an important point.

Mary Jo: Yes. I have a client who when, in her particular frozen state, says to me over and over: you don't understand. You don't understand. And it took me awhile to realize – as Dick would talk – that that was a part of her that when she goes into a trauma state, that's what she says. Her danger is to not be understood and she repeats it. And so at the time I'm saying: okay, well this is what I think is happening. Or: try to explain it to me. Which would just keep her feeling not understood. And I would experience as, I don't know what I'm doing. I'm failing.

Versus it took me awhile to go: wait a minute. What's happening with me? I'm feeling inadequate, I'm feeling vulnerable. So I'm not attending to what she's saying. I really am not understanding what's happening to her at the time. And so I had to get myself in a position of not feeling inadequate. Being: how can I be present? What does she need right now? What is happening between us? Other examples is when I find myself in the middle of a session writing my grocery list. The client's talking and all of a sudden I'm like – and I then I have to go: wait a minute, Mary Jo.

If you're writing your grocery list, something just happened in that room. Or looking at the clock and wishing it was over. Any of those. Or seeing my own heart rate. Or my back starts hurting. Or I can't breathe. Being aware of myself in relation to what's going on.

Rich: This is great because both of you guys have written some of my favorite *Networker* articles over the years about the therapist's transparency. We all – if we're honest with ourselves – experience things like that all the time in our work. What distinguishes the two of you is this particular way that you have of sharing that and bringing that back into the process that would be difficult – for lots of therapists would be really hard to imagine. Recently, just a few issues back, you did a piece called *De-pathologizing the Borderline Client* where you're describing taking the kinds of responses that you're having – that Mary Jo has just been sharing with us – and then bringing that back into the therapy in different ways.

Can you talk a little bit about what your ideas about therapist transparency and self disclosure in working with people who are traumatized clients or clients who have experienced this kind of complex trauma?

Dick: Yes. Let me elaborate on what Mary Jo laid out, because I agree with her. For me, this topic is probably the most important and least really written about in trauma work. And that is the parts of the therapist and the self of the therapist. As you work with this intense rawness in other clients, it's inevitably going to trigger the parts of you that might be stuck in similar places or what I call your exiled parts. And because we all have similar kinds of protective systems that we don't want to experience that, too; as we get stirred up by the work our client's doing, we're going to be distracted. Like Mary Jo said or thinking about the grocery list or try the parts of us that keep us from that material will start to come out, too, and get activated.

And our client will sense that. They'll sense that we're not with them anymore, even if we're not overtly showing that. And, there's a kind of ethic among therapists to try to act together all the time and to pretend like: no, I'm still here with you. And when you do that, when you get distracted and then you come back and say to the client: no, it's your imagination. I'm really still here. I want to keep going. Then, you lose a lot of credibility and there's a sense that you're not somebody who's safe anymore. And I used to do that with clients. And I was very, very lucky to have a couple clients who came in and said: don't do that, I know you're lying. Just tell me the truth. And so I took that risk and started telling the truth. And they loved it. It turned out not just her, but all these clients love it when they bust your parts and you say –

Rich: Just give us the flavor – again, concisely – of the kind of thing that you copped to with these clients who did you this favor of confronting you in this way.

Dick: Okay, I'll give you one quick story. I had a client who we would spend a lot of time in a good place. And I was in myself and warm and open. But the last five minutes of the session, this terrified little girl would take over and pop out. And I'm going: oh, my God, I've got five minutes. How am I going to let her leave like this? So that part of me that's feeling – oh, get out of here – but I'm trying my best to say the right things and be calming and it's going to be okay, we only have five minutes left but you'll be okay. So this happened maybe five times in a row.

I don't think it was five times, but a number of times in a row. And finally, between sessions, she calls me and says: you know, at the

end of the session when that little part of me pops out, you shift into this total asshole. Earlier, she felt like she was coming out to be greeted by this warm, caring guy. And all of a sudden you're this total other person who's – and she used the word asshole.

Rich: It's the therapeutic functionary and not this person that she has a relationship wit.

Dick: And she says: if you would just stay, that's all she wants. She just wants to meet this guy that seems okay. She's been waiting 45 minutes and she finally gets the courage to come out and you leave. It's a bait and switch. So I tried that.

Rich: So how did that sound when you were more from your authentic self as this little needy girl, this kind of girl, comes out. What did it bring out in you? What you actually did with her that felt more like –

[Crosstalk]

Dick: Once I got the phone call and learned?

Rich: Yes.

Dick: I just said: I'm so glad you're here. I know it took a long time for you to come and check me out. You're really welcome here. You can come out earlier next time. We want to help you. We're going to get to know you. Just like that. And she calmed right down.

[Crosstalk]

Rich: Once you got past it, it wasn't that hard to know how to respond.

Dick: Yeah, you just lead with an open heart. You don't let these parts close your heart to people. So that was a huge lesson to me. That and a number of episodes like that. Where it isn't just disclosing what's going on but it's staying in this place and noticing the parts of you that come and close your heart or take you out, disassociate you. And then not only speaking about it during the session, but also using that to follow up and go see a therapist, yourself and follow what we call that trailhead to find the part of you that you need to heal. So my clients have been great what I call tormentors, with a hyphen between the tore and the mentor. In that they bring

up stuff in me that I, then, have to follow up on. And I do it, and it's really made a difference in my life.

Mary Jo: I would say the one thing that I would add, is that I think that what Dick just described – what I advocate – is two things. What we're really talking about is transparency. And if you think about it in terms of healing, that has been missing in the relationships where complex drama happens. That when someone's violated in a relationship, there isn't the transparency. There's the blaming, there's the faux self that's there. What Dick and I are both talking about is that that transparency in and of itself is healing. To be in the relationship with somebody who's an intimate relationship with somebody who does have power over them. However we try – there is some hierarchy between therapists and clients.

So here we are, people in a position of intimacy, in a position to form attachment, in a position of hierarchy that is behaving completely different than many of the other people who have violated them. And the only piece I would add is I think – so part of a therapist's mistake and this would be how to rectify this mistake, and what I've talked about with you a lot, Rich, is that shouldn't be part of the therapy. That when I start seeing any clients that I say I want to be transparent, this is what's going to happen. If this is what happens in the process, and I invite them to make that phone call at the beginning to say: if you find things that are happening in the session, if it feels like I've tuned out or that I'm not understanding, or I want this to be an ongoing relationship where you, as Dick called – you call me out.

You point out to me what's the experience that we are both in an interaction together. So I think that should be part of the therapy. Is that in those first few times you meet someone, to talk about transparency and to talk about what they can expect from me as a clinician on lots of different levels. What you can expect in terms of when I return phone calls or any of that. And the reason that kind of transparency is what I consider good trauma treatment is based on what I just said. Is that we're going to be in a relationship where there's hierarchy attachment intimacy and there's going to be a collaboration and a mutuality where you know ahead of time what you can expect as much as possible. And when it's starting to feel dangerous to you, that you have a voice in this relationship when you sense danger. To talk to me.

Rich: That you have a voice in this –

Mary Jo: That you have a voice when you experience danger in this room.

Rich: What is your experience in – this is a – you're describing, in a way, a kind of a therapeutic apprenticeship, it seems to me, that many therapists don't have in today's climate in this rush and people are stressed and seeing clients. There's a process – this is not something at age 28, 29 you step into a room and you have the presence and the experience and the support and all it takes to become the kind of person who can hang in there and knows how to handle something when you are feeling very emotionally fraught yourself in a way you guys have just described to me quite beautifully. And it sounds very honest and very real.

What's your experience as trainers of people's ability who come into the field, and particularly younger therapists today, to begin to develop that ability? I won't call that kind of a selfhood a kind of more real, fuller, kind of more therapeutic selfhood that certainly has a quality of skill, to be sure, in it, as well. Is this something that's so easily acquired?

Mary Jo: First of all, I'm not even sure I'd call it ability as much as sensibility. Which I think is different.

Rich: Sensibility is something one has to begin with. Ability is something that can be developed. You tell me what you think, bus some people have – and clearly you guys have a sensibility from your earlier days that led you down a certain kind of path. It doesn't seem like it's a universal sensibility, for sure. I'm just curious, as trainers, your ability – is this a therapy for everybody? Does everybody who comes into this field have the ability to either develop this sensibility or manifest this sensibility with time and the proper support? Dick, you want to weigh in on this one?

Dick: Yeah. I don't think it's for people who don't want to do their own work. It's not a therapy for people who want to not really look at themselves and actually, like we're talking about, not just look but also be open about it. So no, it's not for everybody.

Mary Jo: And I don't think it's for people who want to do it in isolation. If you don't want to get supervision – ongoing supervision, ongoing consultation, ongoing training – then it's not for you. I can't imagine doing this work without having colleagues that I can have access to. I still get supervision and consultation. I still work in a

team in terms of so many of my clients where, like I said, I might refer somebody individually to a colleague of Dick and IFS for some of their individual work. But I'm going to be talking to that person on a regular basis about what they're individual work is and so what they're going to be bringing to the couples session or the family session. So this is not for one – just what Dick said – someone that doesn't want to do their own work –

Rich: Who wants a method that they can apply to their clients with a certain predictability to the application of that method. This isn't that.

Mary Jo: This is not for someone that's going to be: I'm going to see six or seven people in a row in my office and then they're going to leave. And I don't have a consultation group, I don't have supervision, I don't have a place, I don't have a team to process not only my own work, but what I'm doing.

Dick: Also, people come out of school with a lot of ideas that get in the way, too.

Rich: Like?

Dick: For example, if something comes up in you and you've been taught that that's projective identification, and that what's coming up in you is really what's coming up in your client, then you're supposed to interpret that to the client. Rather than this might just be your own shit, and you need to get it to get out of the way. That's one example. Or the whole opaqueness of the therapist and how you're never supposed to let the client know if you care about them or not. Which drives survivor clients crazy. Because their safety depends on whether they feel like you really do care about them. So things like that will very much get in the way of actually being able to do what we're talking about.

Rich: So let me ask you. We just have a few more minutes, here. You guys have logged a lot of hours in your offices and been very thoughtful about your work and have had a lot of very varied therapy experiences and have been at this kind of work for 30-plus years at this point. For you, now, what remains the thing that's most challenging? With everything that you've talked about, clearly you've done a lot of work on yourselves. You're two extremely self aware people and you've thought about how therapy works. What's the biggest challenge in doing what we're talking

about here, this kind of trauma work at this point? Mary Jo, you want to start us?

Mary Jo: I think for me, the biggest challenge is having clinicians realize – for me, this is for me – that there isn't one model that works across the board. That really good treatment for complex trauma is an integrated approach. Now, we all can't afford to do it. We all don't work in context that can offer individual, family, and group. Or that can offer both IFS as well as DBD. We don't have that ability and lots of small towns. However, there really isn't one treatment model that works across the board. I have some of my clients where I say to them: stop going and getting training. You're over trained. You need to integrate what you're learning from SE, from DBD, from IFS; all that.

To me, it's really – the biggest challenge is how to stop the rush. Again, it's the pacing. Like we do with the clients. To stop the rush of: I've got to find the one solution. And to be able to pace it and work with the client saying what's going to work best for your own cycle for change? Everybody can change. Everybody is wired to evolve and to grow. We all change differently, different paces, different resources. And to just slow down and work with the client to see what's best going to work for them.

Rich: Okay. And Dick? Challenges for you?

Dick: I think the challenge is to continue the momentum that's been built by people like Bissell and other people toward a new paradigm of understanding mental illness and de-pathologizing the DSM. There's a big movement in England, for example, called Hearing Voices. Where people who have been labeled schizophrenics are taught to relate to their voices in a different way. And they find that it makes a huge difference in – instead of seeing them as signs of being terribly sick. So I think there's been tremendous headway that's been made in many areas and there's still probably the mainstream that really hasn't been touched in terms of how pathologizing our field is.

So instead of seeing this as a disease – and I'm not trying to say there aren't biochemical aspects to a lot of these problems – but to see them as a combination of the impact of trauma or attachment injury or something from the past with a lot of stress in the present that produces these very protective reactions that look really crazy and scare the hell out of people around the client as well as the

therapist into trying to manage and control, which generally just makes these parts that are manifesting the symptoms fight harder for their right to protect and save the – what they think is save the client's life. Because they're also stuck in the past.

Mary Jo: So it did – wait – we're saying a similar thing. Because you're saying an integration. That it's lots of different variables that create what creates what people are experiencing that are coming into our offices and that we can't take a path of pathology biochemic – that it's really an integration.

Dick: It's an integration, but I think my larger point is there's a way – there's a burgeoning movement called Self Compassion, for example, with Kristin Neff and Chris Germer. And so I – and that's been my thing for a long, long time is go to these parts of us that look so crazy with compassion. And listen to them and treat them not like they're sick or out of control, but treat them like they're suffering and they're scared and they're hurting. And if you can relate to yourself that way, then you'll relate to people in the outside world, who resemble those parts, with an open heart, also. So it's more how do we get that kind of a paradigm shift to happen. That's more the challenge for me, I think.

Rich: I want to thank the two of you for this conversation. It doesn't happen often enough in our field and I certainly feel the difference and I'm assuming our listeners do, also of being –

Dick: You're cured, Rich, eh?

Rich: There's a long road ahead but I know where to go with the two of you.

Mary Jo: That's because Dick and I have so much compassion for you.

Dick: As we have to work on a daily basis.

Rich: I keep exercising giving you reason to have more and more compassion for me. So we want to invite you to be part of this conversation. You'll see – and that's really the whole point of State of the Art 2013 – it is a community-wide conversation begun by our distinguished guests here today. So on your comment board that you can see on your screen, a couple of suggestions. One is if you have questions, great. Mary Jo and Dick will look at the comment board. If you ask just the right question, perhaps you'll

get a response. But just the asking of the question and making that public is a service to all of us, is a gift to the community.

If you have comments and your own, maybe some dots – connected some dots and some connections during the course of this conversation, please share that. And here's the question that we have for you, that we had talked – Mary Jo and Dick and I. What's your notion of what's healing in trauma? What is it that makes a difference? How does change take place in your own experience of working with the kind of clients that Mary Jo and Dick have been talking about today, which more and more sounds like all of us and not some distinct category of people on our caseload. Mary Jo, Dick, you guys are great. Thank you so much. What a wonderful conversation, what a great contribution to this conference.

Mary Jo: Thanks, Rich.

Dick: Thank you, Rich.

Rich: That's it for this dialogue. We hope you stay tuned to the State of the Art 2013 and to the other dialogues that are going to be part of this event. But for now, that's it. See you soon.

[End of Audio]

Duration: 69 minutes