From Attachment Wound to Parallel Process.

Embodiment, enactment, and complexity in Body-Mind Relational Psychotherapy.

An Introduction:

"*Everyone who becomes a psychotherapist eventually adopts a theory that suits his needs.*"
Alexander Lowen.

I believe that any psychotherapeutic model must evolve primarily by addressing and working through the characterological blind-spots of the founding parent, and this has certainly been true of Body Psychotherapy.

Wilhelm Reich laid the groundwork for scientifically explaining, psychologically understanding, and somatically experiencing *the embodied psyche*, but remained largely inattentive to transference and, particularly, transferential dynamics; and, therefore, *the embodied therapeutic relationship* has been a large part of the journey of Body Psychotherapy from his to the present day.

I hope that this presentation, by drawing a line from the conflicts of a primary attachment wound through to the subtle dynamics of the supervisory relationship, will delineate an understanding of how Body Psychotherapy has both integrated and greatly contributed to a transferential model of psychotherapy; in which *embodied intersubjective enactment* is understood both as inevitable, and as possibly the principle vehicle by which deeply dissociated attachment-wounds can become available, re-experienced, and transformed.

……..

I will explain how it is that an attachment wound, a primary relational conflict…

- becomes an *internal* conflict, a body-mind object-relation;
- how it then becomes inevitably and necessarily *enacted* in the therapeutic relationship;
- how it then becomes enacted in the supervisory relationship, the subtle dynamics paralleling a dissociated form of the client's primary wound.

The story is passed down from dissociated psyche to dissociated psyche,
in a series of parallel processes, until it becomes experienced.

Inherent in all of my processing of psychological material and theory are several therapeutic positions; in particular:

- Complexity Theory.
- The Embodied Psyche.
- Intersubjectivity.

By Russell Rose 2016

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Complexity Theory:

"*Complex systems are usually systems which have been created by evolution or an evolutionary process. Evolved systems which have a long historical background are nearly always complex. Complexity can be found everywhere where evolution is at work…"*
Cas-group.net

"All open systems - from galaxies to human beings to microbes - operate in a dynamic tension between stable equilibrium and evolving change, between established structure and emerging process. At the boundary between state and process is 'the edge of chaos', where things are complex and in flux, the full picture unknown and outcomes unpredictable - think of the shapes formed by the turbulences of rising smoke or flowing water, sensitive to the slightest environmental change. The therapeutic process is similar."
Michael Soth, Psychotherapist.

"I see the world in very fluid, contradictory, emerging, interconnected terms, and with that kind of circuitry I just don't feel the need to say what is going to happen or will not happen."
Jerry Brown, former Governor of California.

"*Complexity is the prodigy of the world. Simplicity is the sensation of the universe. Behind complexity, there is always simplicity to be revealed. Inside simplicity, there is always complexity to be discovered."*
Gang Yu, a Systems Scientist.

"The art of simplicity is a puzzle of complexity."
Douglas Horton. A Clergyman.

"I think the next [21st] century will be the century of complexity."
Stephen Hawking. Theoretical Physicist.

I feel guided and informed by theories and thoughts from all over the place, but one that is increasingly central to my experience and processing is Complexity Theory, which I believe has a considerable impact on how we understand the human psyche, which is itself a **Complex Adaptive System**.

It is complex, in that there are a large number of diversely interacting elements, and its systemic structure cannot be accurately known from the individual characteristics of its elements.

- This describes the structure of the psyche well, innumerable body-mind elements contributing to a coalescent sense of *self-ness* that is greater than the sum of its parts. There may be symptoms or themes, but they are only a presenting element of a much more complex structure.

It is self-organising, in that a new structure is *emergent* from *within* the interaction of its elements, and it is not controlled or designed from outside the system itself.

- The psyche self-organises. It can be impacted, effected, and influenced by the environment, of course but, whatever new structures emerge from the old, their re-organisation is spontaneous, internal, and indeterminable. Stability and order can be encouraged, but cannot be imposed.

It is non-linear, in that input does not equal output. It is not deterministic. Less can be more. Chaos Theory. The Butterfly Effect.

- The psyche receives input constantly but the effect on the psyche-structure can never be pre-determined. It is not a linear relationship, whereby an intervention could have an accurately predictable impact.

It adapts and learns, in that it can change its behaviour as a result of its capacity to intake, process, and create information. It has rules as to how the environment is related to, feedback loops that inform as to how effective the rules are, and the ability to form new rules from the integration of old rules and the new information.

- The psyche is extremely suggestible, responsive and adaptive in its interactions with the outside environment. Indeed, this is how the psyche forms and develops; by reading, ingesting, mapping, responding and adapting to its relationship with the *outside* as well as the *inside* environment.

It is dynamic, in that it can maintain stability during fluctuation, and yet undergo rapid and unpredictable transformations.

- The psyche undergoes innumerable incremental changes, some which are passing and some which leave a permanent imprint, but which do not unsettle its fundamental stability; and the psyche is also able to deconstruct and reconstruct with movements of more radical character-transformation.

It co-evolves, in that it changes and is changed by its environment in mutual process.

- The psyche co-evolves with other psyches. We co-organise our *dissociated* as well as our *conscious* selves. We regulate and we mutually-regulate, reinforcing each other's structures as well as occasionally challenging or enacting them. A relationship becomes another *complex adaptive system*, and transformational change, for example, is an *intersubjective* dynamic rather than a solitary emergence.

It responds most efficiently at *the edge of chaos*. Systems tend to be ordered, chaotic, or *complex*. Complex Systems have both chaotic *and* ordered areas, interwoven so that the system is both able to maintain stability *and* undergo transformational reconfiguration. The *edge of chaos* is where the system is stable

enough to intake and process new information, whilst being chaotic enough to allow for a new emergent structure.

- If we have too much reliance on stability, nothing much will change; but when the psyche is in *overwhelm*, nothing much can be learnt. The edge of chaos is the place of greatest therapeutic potential, when the client is both stable enough to be receptive and yet chaotic enough to be able to respond spontaneously.

- *Stability* can become *stasis*, and *chaos* can become *overwhelming.*

- Transformational therapeutic moments emerge spontaneously from this edge of chaos, and sometimes the proximity of these moments can be felt, or at least sensed. The edge of chaos has an energetic charge that is palpable.

Aligned with natural-selection in the processes of evolution, Complexity Theory is a theory of nature, and can be used to understand the dynamics of an eco-system, the financial markets, a family-system, ant-hills, murmuration; just for a few of the more every-day examples of something ubiquitous.

Some implications for a psychotherapist:

Symptom based therapy:
Whether a focus of our particular therapeutic model or not, we can all be symptom-focused, if for no other reason then at least because our clients tend to be. I don't have a problem with this, but I think it's important to acknowledge that a symptom, by definition, is simply a presenting feature of a complex systemic structure.

Non-linear:
Psychological material can be reduced into a cause-and-effect model, but it's inevitably an abbreviation of a more complex process. I think that we often have to abbreviate it, in order to find some kind of narrative to work from, but the danger is that we squeeze our *experience* of the real process into the confines of our abbreviation.

Certainty and Uncertainty:
A sense of certainty is one of the feelings that I have come to least trust as a psychotherapist.

In the interaction between two complex co-organising psyches, almost everything is unknown, so any certainty that I feel can only at best ever be a relevant distraction. Certainty builds stability and working-alliance; but uncertainty is where the change and transformation happen, when psychological

structures begin to break down and spontaneously re-organise; at the edge of chaos.

I like the Heisenberg Uncertainty Principle, but as a metaphor only; basically, that we can only know one thing by not knowing another.

Uncertainty helps us to stay near to the edge of chaos.
Certainty helps us to stay near to the edge of stability.

Less is more: (relating to chaos theory)
Input does not equal predictable output. A seemingly minor intervention can have a dramatic effect; at times even have a considerable cascading effect as it impacts upon different relationships outside of the therapeutic encounter; just as a seemingly profound realisation can transpire to have surprisingly little on-going impact on the client's functioning psyche.

Stability and Chaos:
Stability and chaos are two aspects of the same system, co-organised as well as paradoxically oppositional. They exist of and because of each other, and it's the dynamic tension between them that needs to be experienced and managed.

We each have our own subjective relationship to *stability* and *chaos*. We will each have a habitual position regarding how much stability we invest in, we will each have a habitual and reactive position in relation to particular themes or dynamics, and we will have a co-organised habitual *relational* position.

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The Embodied Psyche:

'In PTSD a traumatic event is not remembered and relegated to one's past in the same way as other life events. Trauma continues to intrude upon visual, auditory, and/or other somatic reality on the lives of its victims. Again and again they re-live the life-threatening experiences they suffered, reacting in mind and body as though such events were still occurring. PTSD is a complex psychobiological condition."
Babette Rothschild. The Body Remembers: the psychophysiology of trauma and trauma treatment. 200

"Every muscular rigidity contains the history and meaning of its origin. Its dissolution not only liberates energy…but brings back into memory the very infantile situation in which the repression had taken place."
Wilhelm Reich. The Function of the Orgasm. 1937

"Nature appears to have built the apparatus of rationality not just on top of the apparatus of biological regulation, but also from it and with it."
Antonio Damasio: Descartes Error: emotion, reason, and the human brain.

"…our body, like our psychic properties and potentialities, emerges out of the emotional ambience and bodily-interaction with our care-givers. Our personal body unfolds and develops its individuality in the context of its relationship to and with an other and other bodies.
Suzy Orbach. The Body in Clinical Practice

"The body is anchored in the here and now while the mind travels to the past and future."
The Buddha

I understand the Body and Mind to be mutually informative, mutually responsive, and mutually dependent in the on-going expression and development of the psyche and the sense of self.

This guiding premise of Body Psychotherapy can be seen as being in opposition to the implications of Descartes' Dualism, given legend by the phrase "I think, therefore I am", in which the processes of the *dynamic mind* are understood as being separate from the processes of the *mechanical body*.

It's been eighty years since Wilhelm Reich began to demonstrate the bio-psychologically interwoven nature of the body and mind; and for Reich, 'Character Analysis'. (1934) was the natural elaboration of Freud's largely discarded search for *the biological psyche*.

Muscular structure and expression, emotional somatic sensation, subtle body, cognition, and energetic processes were linked to The Autonomic Nervous System and developmental stages, in a holistic model that understood trauma to be complexly in-laid into the complex body-mind system; forming, what he referred to as, Character Structure.

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It has now been twenty years since neuro-science both demonstrated and began to greatly elaborate upon Reich's early work; but yet our cultural understanding hasn't shifted much at all. We speak about the body in the third-person, as something that we *have* rather than something that we *are*. It seems increasingly our cultural habit to use the body as a fashion-accessory, as marketing for the false-self, and we tend only to address it when it is not working properly or when it is imagined to be imperfectly formed.

Experientially we haven't caught up with our own science yet; in itself, a good example of a body-mind split. We *know* it, but resist *being* it, and are culturally inattentive to this pervading conflict.

The brain is body, as are the nervous, hormonal, muscular, digestive, circularity, and respiratory systems; all of which being mechanically and energetically responsive and adaptive in times of emotional conflict or trauma, individually and systemically.

The Enteric Nervous System of the gut, comprising an estimated 100 million plus neurons, is often now referred to as the second brain, and is increasingly being recognised as a highly significant organ in emotional processing and intuitive resonance. The vagus nerve connects the guts and the brain, and it's interesting to note that 90% of the information that travels the vagus nerve goes upward from the gut to the head. It's the guts that largely inform the brain, not the other way round.

Most of this is of course unconscious, but it's a central aspect of the practice of a Body Psychotherapist to spend time connected to the sensory movements of the enteric nervous system. It's often the famous gut-instinct, the intuitive brain, that informs me of conflict within myself, of dissonance in the therapeutic relationship, to know when something feels at odds with the narrative, when something is happening that I'm not consciously aware of.

And, beginning with Antonio Damasio, Neuroscience has clearly demonstrated that even the most concrete of *rational decision-making* relies, first and foremost, upon *somatic markers*, intuition and emotion. Just because we are not always aware of the influence of our somatic-emotional response upon a supposedly-cognition moment does not mean that it's not happening.

So I would say that, theoretically at least, I *am* my body, and my mind, every subtle complex feedback loop between them, every sensation, spontaneous

movement, habitual structure, every intuition, every thought and reflection, every image, pattern of tension and collapse; *and* every conflicted opposition between these various aspects of myself.

The body and mind are entirely interwoven aspects of each other,
and their innumerable elements constitute a Complex Adaptive System.

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Intersubjectivity:

"*…just how ubiquitous it is and how equally inevitable is the evocation of the analyst's past in terms of re-creating an emotional scenario*."
Maroda 1998

"With regard to psychological development, for example, we have proposed that the "organization of the child's experience must be seen as a property of the child-caregiver system of mutual regulation" and that it is the "recurring patterns of intersubjective transaction within the developmental system [that] result in the establishment of invariant principles that unconsciously organize the child's subsequent experiences"
Stolorow and Atwood: The Intersubjective Perspective. Psychoanalytic Review 1996

"Any pathological constellation can be understood, from our perspective, only in terms of the unique intersubjective contexts in which it originated and is continuing to be maintained."
Stolorow and Atwood: The Intersubjective Perspective. Psychoanalytic Review 1996

"There is no such thing as a baby, there is a baby and someone."
Donald Winnicott.

Central to my processing is *Intersubjectivity*, a tenet of which being that all psychological material in the therapeutic encounter is co-created. Transference isn't always one-way or even bilateral, but a coalescence of mutually dissociated energies that sometimes rise in consciousness far enough to be abbreviated into a named transference or counter-transference.

I don't understand how psychological material could be anything other than co-created within the therapeutic encounter. It is how humans subtly interact, and the various conscious professional structures that we put in place, whilst serving to analyse and understand subtle organizing dynamics, cannot protect us from becoming unconsciously involved in them.

From the beginning of life, the mind is being nourished and built *not in isolation* but in the context of *an other* and, although as we get older we hopefully develop a clear separate *sense* of self, our *dissociated* selves continue to co-organise relationally and systemically.

We construct each other in terms of transferential perception, and we construct each other in terms of transferential experience. We read, ingest, and map into each other's psyches through non-verbal communication that includes energetic exchange; subtly co-regulate *and occasionally trigger* each other's wounds.

Our respective complex adaptive systems form a *relational* and *systemic* complex adaptive system, feedback loops meeting feedback loops in a continual

interwoven exchange of information and energetic resonance; seeking *stability and* seeking *the edge of chaos* from where an evolved new structure might emerge.

The possibility of psychological material being anything other than co-created feels remote and counter-intuitive to me, and I always assume that I'm an active unconscious aspect of whatever story unfolds in therapy; not so much that I've *become* an aspect of the story, but that I *am* an aspect of the story; and vice versa.

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Attachment wounds *to* Internalised Body-Mind Object-Relations:

"*…I have suggested that pathological dissociation represents an early forming bottom-line right-brain survival defence against overwhelming, unbearable, painful emotional experiences, including those generated in relational attachment trauma*."
Allan Schore. The Science of the Art of Psychotherapy.

"…the only reason and the only way a past wound can re-appear and be re-experienced in the client's current life (as well as manifest in the here-and-now interaction between client and therapist) is because it has been internalized and stored. Wilhelm Reich showed that the bulk of this was not a mental process, but relied on 'body memory': our accumulated life experience, our whole life history – including our unresolved traumas and wounds – is frozen into our organismic system across all body-mind levels, as a habitual pattern he called 'character armor'. When a wound is frozen in time and structured into the bodymind, what this means in simple terms is that on some level of somatic reality the trauma is constantly experienced as if it were happening NOW."
Michael Soth: How the wound enters the consulting room.

"I would rather be the child of a mother who has all the inner conflicts of the human being than be mothered by someone for whom all is easy and smooth, who knows all the answers, and is a stranger to doubt."
Donald Winnicott.

Attachment wounds begin as relational wounds, with conflicts or ruptures in a primary relationship remaining unresolved, and becoming integrated into the psyche as conflicted body-mind objects, *that are a parallel of the primary relational conflict.*

Any level of body-mind *experience* and *conflict* will carry a representation of an aspect of the primary scenario; and if we bear in mind all of the factors that need to be considered in body-mind emotional processing, we can see that there a considerable potential for conflict. For example:

- The initial startle-reflex, the immediate bracing against shock.
- The instinctive fight or flight response.
- Possibly a more considered fight or flight response.
- A habitual fight or flight response, in conflicts that are repetitive.
- A counter-habitual fight or flight response, the urge to challenge the habitual position.
- Preservation of physical health.

- Preservation of psychological stability.
- Preservation of dignity and self-esteem.
- Preservation of the stability and self-esteem of *the other*.
- Preservation of the relationship.
- The need to release the pressure of unmanageable feelings.

There is broad scope for conflict, and each urge will be represented by unique somatic patterns of tension and physiological process. In attachment crises there will be conflict between different positions, as some will fundamentally support each other whilst others fundamentally won't. These conflicts can be worked through or exacerbated at several different stages in the process of emotional integration.

- There is the duration of the initial wounding relational experience.
- The phase of body-mind expressions and inhibitions.
- The phase of physiological release, such as crying, panting, sweating.
- The phase of reflection and unwinding; trauma receding.
- The phase of body-mind integration, and relational integration.

At any of these stages, the wound can be unwound and understood, exacerbated, repeated and reinforced, or a secondary wound thrown in. In on-going attachment wounds, it can obviously be assumed that these opportunities for release and integration have not been navigated healthily; and that, especially if repetitive, which attachment-wounds tend to be, considerable body-mind adaptation may be needed to cope with the pressure of conflicted positions.

Patterns of tension become fixed in habitual positions and conditioned-responses, each a parallel of the primary conflict; and aspects of the wounding drama become internalized as *conflicted body-mind object-relations*. These might relate to subjective states, interactive states, or frozen moments; seen, felt, heard, or sensed.

Words and phrases, facial expressions and body postures, attitudes and dynamics; dramatic and subtle psychological adaptations, respiratory patterns, energetic resonance; any might represent frozen moments from a primary drama.

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In service of inner and relational equilibrium, some aspects of this internalization will be identified with, some dissociated from, and the body-mind ego-structure will re-configure to support the manageable version of the story, rather than necessarily the story itself. What is dissociated from will express itself in non-verbal communication, the well-spring of transferential dynamics.

The attachment wound is internalized as
conflicted body-mind object-relations.

The *relational* conflict becomes an *internal* conflict,
An enactment and parallel of the primary attachment-wound

When David broke down in therapy, when he was emotionally overwhelmed by it all, he became violently angry with himself, then looked terrified; in a perfect rendition of the triadic family dynamic of his mother routinely falling to pieces, his father routinely responding with anger and occasional violence, the little boy listening in from his bedroom door, terrified.

Each character from the primary drama was present, enacting the story over again from within David's body-mind system; the primary attachment trauma dynamically internalized, accessible again in his body-mind relationship with himself.

His whole body-mind moved from being excessively distraught about something, to being angry with himself, to hitting himself, to looking scared. When these episodes happened, I went through the gamut of feelings myself, but strongest in me was anxiety, because I just did not know what to do.

Internalised Body-Mind Object-Relations *to* Enactment in The Therapeutic Relationship:

"…this is the central paradox of our profession: the re-enactment of the wound and its transformation occurs spontaneously. In surrendering to the re-enactment, the therapist has a sense of losing their position, and the last vestiges of medical-model duality – of the therapist remaining outside the wound, supposedly acting ***on*** *it – are temporarily deconstructed. In the language of complexity theory, at this chaotic-edge, far from equilibrium, a new configuration of the system can emerge*."
Michael Soth: 'How the wound enters the consulting room."

"It is now a clinical truism that experience dissociated in the strong sense – dissociated with unconscious defensive purpose – does not simply disappear into some untended part of the mind, but is instead repetitively externalized, unconsciously enacted in relationship."
Bromberg: 'Standing in the Spaces: essays on clinical process, trauma, and dissociation.

As psychotherapists, we all know the experience of clients acting out old wounded dynamics within significant relationships, and it's very often that which brings a client to therapy in the first place. Humans seem to have an uncanny capacity to choose partners with whom we either re-enact certain primary dynamics, co-organise in defensive dissociation from them, or both; and it seems to me that it is the navigation of these conscious and unconscious patterns that determines whether a relationship can both co-evolve *and* maintain its fundamental stability. This is true of the therapeutic relationship also.

This is one of the primary underlying issues for the infant in an attachment-trauma: there is the need to *evolve*, for example from dependence to independence, and there is the need to maintain the *inner* and *relational* sense of stability.

- The need for inner stability.
- The need for inner evolution.
- The dissociated, habitualised and *conflicted* relationship between them….
- ….brought inevitably into the therapeutic encounter, both in conscious and dissociated aspects.

As psychotherapists we are well placed to unconsciously receive and inhabit this conflict. We are charged with deconstruction, with change and transformation,

and yet we know that we must have a working-alliance strong enough to withstand any ruptures that will inevitably happen along the way.

We too are heavily invested in both *change* and *stability*. We want our clients to be able to face the unbearable, without it being unbearable; and our clients enter the therapy room wanting change, otherwise why be there, but are deeply resistant to the change that they crave, otherwise why *need* to be there. Even the most fragmented of clients is usually trying hard not to break down.

From the beginning, we are ripe for transferential and counter-transferential construct, and the intimacy, intensity, structure, and reflective capacity of the therapeutic encounter makes it inevitable that the two psyches in the room will be either co-organised around the wound, or organized around the defensive adaptations to it, or both, whilst the mutual need for stability *and* change co-organizes itself from moment to moment.

This is a largely unconscious process by definition, as it is the dissociated aspects of each self that are doing most of the co-organising, expressed in non-verbal communication that is read and ingested through right-brain to right-brain mediation, and mapped into the respective psyches by mirror neurons; effectively conjoining into *a relational body-mind system*, *a relational character-structure*, that is, in one way or another, a parallel representation of the wounded patterns of both participants.

It was in supervision that I came to understand David's expressive relationship with himself to be a body-mind object-relations parallel of a primary attachment scenario, and it was a revelation to me.

I had generally understood body-mind patterns as incomplete *internal* processes, and seeing that they could equally be frozen moments ingested from *anyone* or *any dynamic* within a primary scenario opened up my mind to the dynamic complexity of the psyche. We were, at least in part, composites of each other.

I believed intuitively that I was playing a role in this primary drama, that I wasn't just an observer, not just a witness but a participant in some way; and I decided that my job was to change the dynamic structure of the triad by stepping into it. David's father clearly had insufficient patience for his wife's anxiety, lapsing quickly from reassurance to anger to violence, and so I became highly engaged with David's distraught self.

In terms of presenting issues, *his distraught self* was thoroughly unrealistic. He imagined terrible consequences as a result of simple mistakes or errors in his thinking, that his life would now be ruined for example by forgetting to respond to an email about work, or by saying something to a prospective girlfriend that might have slightly upset or challenged her. Interesting though that he never

seemed to apply this to our relationship. He could be an absolute nightmare in sessions, but didn't seem to doubt my commitment to him.

I patiently explained things over and over to him, encouraged him to dis-identify with this panic and educated him about how to calm himself down, how to soothe himself, to separate himself just enough from his self-deprecating narrative to be able to see it as an unreliable interpretation of the sensations in his body.

However, he compulsively deflected me and my patient support, elaborating barely-rational arguments why this didn't make sense, why that wouldn't work, explaining that I just didn't understand; and so on. The only ever possible consequence was always bleak.

I became increasingly frustrated with him. I found him irritating, intransigent and stuck, unresponsive to obvious reason and common-sense. I held on to this irritation, of course, and imagined that it wasn't spilling out into the therapy, but I became aware of a quite distinct and disturbing pattern, whereby he would be more likely to become angry and hit himself the more irritated I secretly felt towards him.

I had become his father in the triadic drama, imploring the distraught mother to listen to reason, only eventually to lose his temper. I wasn't aware of feeling violent towards David, but he nevertheless completed the story by hitting himself.

I was upset with myself, and resolved to target the aggressor instead of unconsciously inhabiting him, figuring that one thing that had been missing in the primary scenario was someone able to stand up to the father. Heroically, I stepped in.

I quickly got into an argument with *his violent self*, refusing to support his self-attack by reminding him that he was being to himself as his father had been to his mother, and on a couple of occasions I stepped in physically, and restrained his fist.

David was furious with me, and I imagined that I was in combat with the father, who had finally found someone who could stand up to him, who was unafraid of his threats. However, David countered me with ease by arguing that it was surely better to hit himself than to hit someone else or kill himself, both being '*what he really wanted to do*'. This put me into a dilemma because, quite obviously, I too preferred him to hit himself rather than hit someone else or kill himself.

I felt hugely emotionally manipulated though and furious, and expressed a version of this to him. He expected me to have to witness violence *tacitly* for fear of the threat of escalation. He responded by hitting himself, defiantly and, in a moment of impotence, I told him that if he continued to do this I would stop working with him.

He hit himself defiantly again, and the lie was exposed. I was left feeling powerless, and aware that I had walked into another perfect enactment, the primary version of which being the repeated threats of divorce that David's mother never followed up. She felt powerless and so did I.

The *internalised* conflict is re-externalized into a *relational* conflict;

An enactment and parallel of the primary attachment-wound.

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Parallel Process: The Supervisory Relationship.

"...processes at work currently in the relationship between patient and therapist are often reflected in the relationship between therapist and supervisor."
Harold Searles. Collected Works 1955

"Parallel process [is] a fractal of the field....representing (even though in minute form) the structure of the larger whole....No matter how small the size to which it is reduced, the essential features of the field will remain present and available for inspection."
Petrūska Clarkson. Countertransference, and Parallel Process in Transactional Analysis Psychotherapy and Supervision'.

"*As supervisors we are as much a part of the systemic field as the supervisee or the client. We are a subsystem within the treatment system....We are in a web of mutual co-creation of the story and of the frame within which that story is understood from the moment that the system emerges."*
Geoff Mothersole, 'Levels of Attention in Clinical Supervision

"*Parallel process cannot happen if one person is totally healed, it can happen only when an unconscious process of one person touches the unconscious process of another person. Therapeutic task is not to stop this process, because it is not possible, but to figure out its meaning and find a way to bring it at a level of consciousness. The touch of the two unconscious processes is a space for growth for both sides; it is a chance for the development. A client, therapist even a supervisor, they all repeat their history. It is inevitable, it is OK. Impasses in therapy happen due to not recognizing relational unconsciousness."*
Ken Evans. 2007 Oral Lecture

Parallel Process is the term applied to the experience of the underlying dynamics between the psychotherapist and supervisor *paralleling* the story of the client's dissociated psyche and attachment-trauma. The dissociated dynamic is enacted by them, and it is hoped that the relative distance from the immediacy of the client makes the relating-pattern more likely to be noticed.

Parallel Processing works in the same way as the conversion from internalized object-relations to enactment dynamics; non-verbal communication, right-brain to right-brain processing and mirror neurons passing the dissociated patterns down the line until they are seen.

First described, so far as I'm aware, by Harold Searles, Parallel Process was brought more into the mainstream understanding and application by Hawkins and Shohet with 'Supervision in the Helping Professions.'

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I came across 'Parallel Process' in the first year of my practice, in 1996, and it had a profound effect on me. It gave me a context for the sense that everyone entering a psychological field co-organises around and within it, and it gave direction to the early stages of my career.

Shortly following my qualification, I began working for a couple of organisations who supported people with mental health issues and learning disabilities in the residential settings. I ran a variety of groups on, in generalized terms, the integration of psychotherapeutic principles into those of the residential support service.

My passion though was for trouble-shooting, for working with a whole staff-team regarding a specific client who would be either in some kind of psychological rupture or a fixed behavioural pattern that remained unresponsive to normal interventions.

By some distance, the most useful perspective for me was Parallel Process, as I consistently experienced that an attention to the underlying dynamics between those of us in the training-room would come to tell us the story of the client's underlying wound and inhibiting conflict. It was rare that we were unable to elicit significant change in the client by an attention to ourselves.

These consistent experiences gave weight to my sense that, first and foremost, it was the here-and-now relationship that needed to be healed.

For further reading, please visit my website at **russellrose.co.uk**
In the 'Articles' section there are several articles on this work with Parallel Process in groups. For examples:

- Forced Feeding. 1999
- Fried Breakfast for the Soul. 1999
- Bobbing on the Surface. 2003

I felt at breaking-point, and started to become fearful of our sessions. I didn't know how to respond to him. Everything I did felt wrong, and I was confused and anxious most of the time.

I was also annoyed with my Supervisor. We were completely locked-up, and I was really feeling like the junior therapist that I in fact was. I needed him to come up with something. However, he owned up to feeling much as I did, including feeling irritated with me for 'mistakes' that I, in turn, felt that he had encouraged in me. Neither of us knew what to do.

It was only when I inhabited and owned just actually how scared I was about going back into the room with David that the story opened up for us. My

supervisor admitted that he hadn't been really taking my fear seriously, that he had figured that I was sturdy enough to survive it.

Generally I would say that I am pretty resilient. Not that much scares me in the therapy room, and in any case I don't feel particularly scared of being scared. However, it's also a habitual position of mine to refuse to succumb to fear, and to thereby ignore it. This aspect of me I affectionately refer to as my Adolescent Hero, courageous and kind but driven at times by misguided imperatives and an inclination to disregard his own feelings.

My supervisor also owned that he too had been feeling quite anxious about talking about David with me, because he hadn't known what to do either.

He hadn't fully engaged with my fear, I habitually ignored my fear, and neither of us had noticed the significance of this underlying dynamic in my client's story; the little boy in the doorway of his bedroom, terrified as he listened to the escalating chaotic drama. I was scared of entering the room that he was scared to leave.

Whereas our previous *enactment insights* had excited me, albeit temporarily, this one didn't. I felt upset, scared, and guilty. I was a part of it, rather than acting upon it.

From Parallel Process *back to* the Therapeutic Relationship:

When David next went into this triadic re-enactment, I pretty much ignored the aggressive father and the over-wrought mother, focusing almost entirely on the terrified child; and I did so with a strong sense of guilt that I had not done so before - an enactment, we might say, of how his parents *should* have felt had they found their way beyond themselves and even wondered about the impact of all of this on their boy.

The first few times this happened, the anxious mother become louder, or the aggressive father more threatening, but I felt quite clear that she got on my nerves and that he didn't scare me. It wasn't long before David stopped hitting himself and the child began to emerge from the bedroom door.

David admitted to an agoraphobia that he'd hidden from me. He did go out, but rarely, reluctantly, and almost never socially. He felt that he didn't understand how the world worked, and felt scared of imminent violence. He had never really been able to leave the slightly-ajar bedroom door and step into the world beyond.

Gradually over the next couple of years, I spent a lot of time with his fear of life, traumatised into his body-mind system. I worked hard at calming him down, at slowly teaching him how to calm himself down, at dis-identifying from his fearful narrative and embodying the realisation that he was responding to the world as a little boy might, rather than the somewhat strapping adult that he'd grown into.

I encouraged an image of his fully-grown man leading his little boy out of the bedroom and into the outside world, assuring him that I felt confident that he would and could protect him. For a while he referred to the image, but as his confidence grew so did his inclination to visit places that children wouldn't be allowed in to; and he stopped taking about him.

The last I saw of David he was in an established relationship, the first he'd ever had, and was thinking hard about getting a job.

Therapeutic Ruptures and Therapeutic Stasis (chaos and stability):

"If we cling onto the working alliance, we might miss the rupture."
Michael Soth.

This example with David involved successive ruptures to the working-alliance, and it was clear that we were replaying fragmented aspects of the primary scenario but, at least equally as likely, enactment is revealed by ***therapeutic stasis***, when nothing is happening but repetitive circles, and change seems frustratingly far away.

My working-understanding is that ruptures *tend* to be enactments of primary dynamic scenarios, in therapist or client or both, and that stasis tends to be an enactment of the defences against them.

Michael Soth identifies four generalised therapeutic positions within complexity:

- the *stable* can slip into *stasis*
- and the *chaotic* can slip into *overwhelm*.

Each person in the room has a relationship to and investment with each position, both habitually and in response to specific themes but, whereas therapeutic ruptures tend to become apparent, therapeutic stasis can remain comfortably hidden within a strong working-alliance.

In terms of complexity theory, we might see the correlation between *ruptures* and a systemic-structure that has tipped into *overwhelm*; and likewise *stasis* with a habitual stability too far from the edge of chaos to facilitate a change.

For me, these are useful questions when I suspect a *therapeutic stasis*.

- What is *my* habitual position with both chaos and stability?
- What is *my* client's habitual position with both chaos and stability?
- What is *our* habitual relationship with both chaos and stability?
- How am I collaborating to keep us away from the charged edge of chaos?

- What am I doing or not doing that maintains the habituality of the encounter?

- Am I extinguishing charged moments?
- What is my therapeutic position, and what is my shadow-therapeutic position?

- How am I supporting exactly that which I believe myself to be challenging?

In conclusion:

We unknowingly know each other's unknown secrets, in-lay them within our respective body-mind psyches, co-organise around them, and co-create psychological material whilst erroneously assuming ourselves guided by individual free-will.

Far from being psychological islands, our frontiers are so overlapped that, to some large extent, *the sense of self* is a scarily abbreviated version of an unimaginably complex, body-mind, relational process.

Given the intensity of the therapeutic encounter and all of its structural encouragement of stability and containment, along with its awareness of the need for deconstruction, it should not be surprising that we unconsciously meet, merge or collide with our client's paradoxical investment in both stability and change.

We share an inherent mutual conflict between *the need for change* and *the need for stability*, the need for a new emergent structure and a continued investment in the comforting familiarity of the habitual.

If psychological co-organisation is inevitable then so is *enactment*; benign or vitalised, but ever-present; and I believe that our job is not to avoid it, but to allow ourselves to step in to it; or, more precisely, assume and seek to notice *that we already have*.

Either the wound is open and enacted in the room, or it's not. If it's not, then it's being defended against. And if it's being defended against, then the resistance will be collaborative.

I think that enactment is *a therapeutic-given*, and I very much agree with Appendix 3 by Michael Soth, that the theory of enactment has travelled a similar path to that of transference and counter-transference; from being seen as irrelevant, to being seen as intrusive, *to being seen as the work itself*.

To this extent, I believe that first and foremost it is the therapeutic relationship that needs to be, for want of a better word, *healed*.

Appendix 1: From Primary Wound to Parallel Process. A simplification.
Appendix 2: A list of dualisms that I find useful.
Appendix 3: 'The Three Relational Revolutions:' by Michael Soth
Appendix 4: "Extending and Expanding our notion of Parallel Process." By Michael Soth

From Attachment Wound to Parallel Process.

Embodiment, enactment, and complexity in Body-Mind Relational Psychotherapy.

Appendix 1:
From Primary Wound to Parallel Process: In simplification.

Primary attachment conflict is

Internalized as body-mind object-relations, then

Externalized in transference and therapeutic enactment, and

Paralleled in the supervision relationship

There are three parallel processes, each a reflection of the others and of the primary attachment conflict itself.

The story is passed down from dissociated psyche to dissociated psyche until it becomes experienced.

See Appendix 4 for a breakdown into 6 parallel processes.

Appendix 2:
This is a list of dualisms that I find useful in my processing of psychological experience. They are all linear abstractions of complex processes.

Right-brain	Left-brain
Expressive forces	Inhibiting forces
Expansive forces	Contracting forces
Experiential	Analytical
Chaos	Stability
Id	Ego
Complex	Linear
Feeling	Thought
Uncertainty	Certainty
Art	Science
Empathy	Boundaries
Therapy as relationship	Therapy as treatment
Therapeutic fragmentation	Therapeutic Stasis
Embodiment	Dissociation
Spontaneous Processes	Reflective Processes
Spontaneous Processes	Habitual Processes
Emergency Mode	Habitual Mode
Connection	Distraction
Paradoxical	Linear
Human Encounter	Professional Encounter
Overwhelm	Stasis

From Attachment Wound to Parallel Process.

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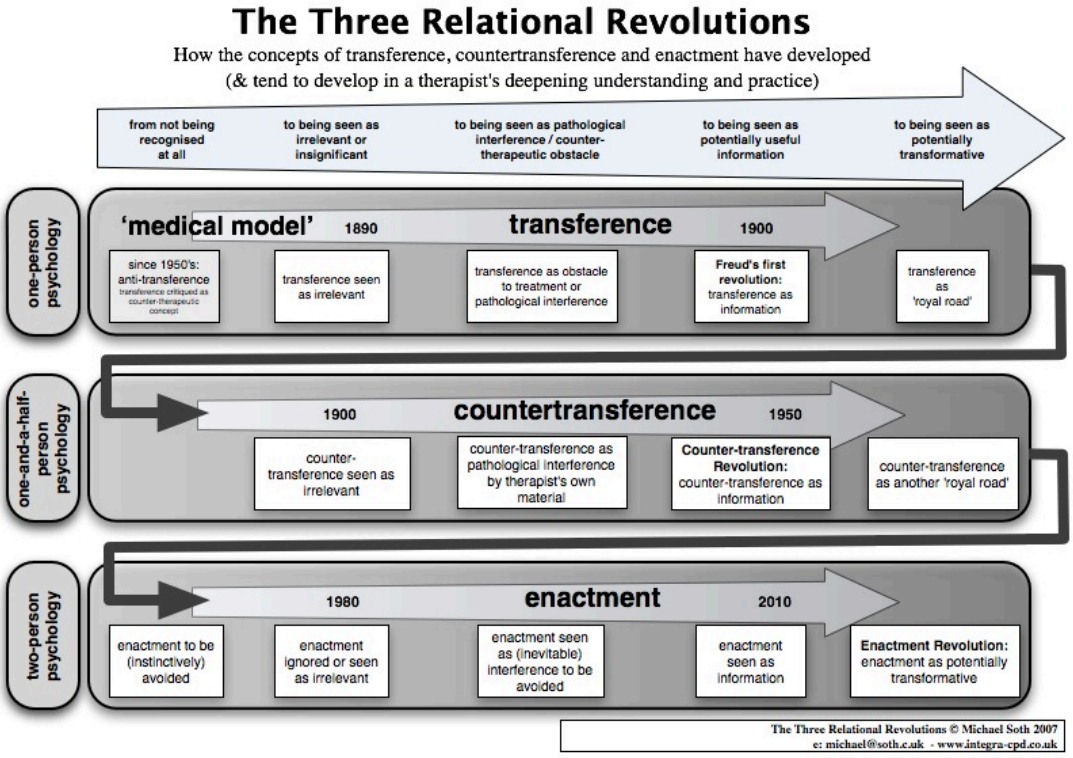
Appendix 3:

This is a diagram from **Michael Soth**, illustrating the development of transference and enactment theory, alongside Martha Stark's Relational Modalities.

http://www.integra-cpd.co.uk/cpd-resources/the-three-relational-revolutions-2007/



From Attachment Wound to Parallel Process.

Embodiment, enactment, and complexity in Body-Mind Relational Psychotherapy.

Appendix 4:
http://www.integra-cpd.co.uk/cpd-resources/soth-extended-model-of-parallel-process-2005/