

**“A Tender Mother May Be There for Me!”:
Forms of Vulnerability and Relational Processes Promoting the
Integration of the Self**

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Abstract

Developed by Richard Erskine and his colleagues, integrative psychotherapy (IP) rests on a deeply relational view of the person. The case study presented in this article demonstrates how the application of IP theories and methods facilitates the establishment of a healthy therapist-patient relationship and the implementation of relational processes promoting the healing of the self. The story of Stella, a 40-year-old woman suffering from a severe form of dissociation, withdrawal, and body armoring, provides a clinical, theoretical, and methodological reflection on how the therapeutic approach of IP as integrated with other theoretical and methodological contributions facilitated her therapeutic process. Among these contributions are Stern's fundamental dynamic pentad and Levine's somatic experiencing.

Keywords: Integrative psychotherapy, dissociation, relational needs, contact in relationship, keyhole diagram, vital forms

Working with people suffering with severe psychological disorders has validated my view on the necessity of therapists maintaining a cautious approach when establishing a connection with their patients. Evidence shows that traumatic experiences occur in therapy because of interruptions to contact in the relationship (Erskine & Trautmann, 1996/1997a; Levine, 2010; Schore, 2003a, 2003b; van der Kolk, 2015). The therapist is in charge of reestablishing healthy contact in relationship, which can replace failed relational experiences in the patient's life so he or she can finally heal.

Integrative psychotherapy (IP) includes complex, coherent theories and methods that promote contact in relationship. A therapist may provide the kind of “therapeutic love” (O’Reilly-Knapp, 2001b) that the patient needs in order to heal his or her wounds and reintegrate the split-off aspects of the self through the therapist-patient relationship (Schore, 2003a, 2003b). This relationship should rely on inquiry, attunement, and involvement (Erskine & Trautmann, 1996/1997a, p. 25) as shown in Figure 1.

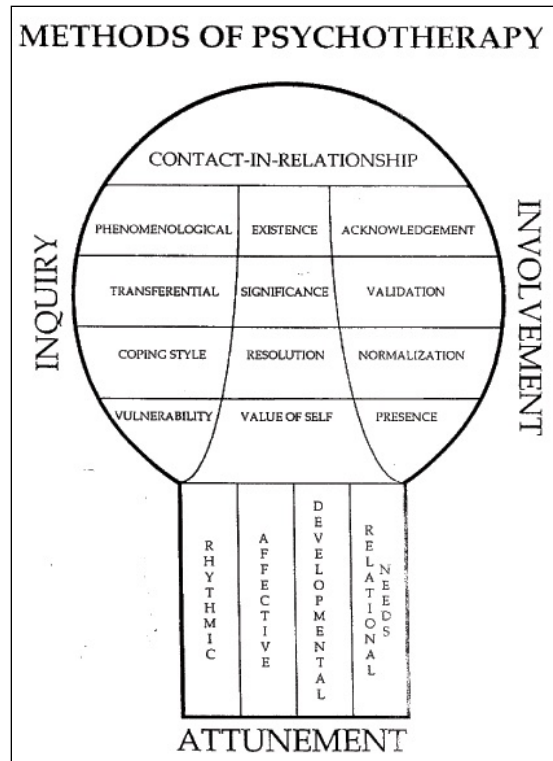


Figure 1. Methods of an Integrative Psychotherapy (Erskine & Trautmann, 1996/1997a, p. 25)

This diagram was later called the *keyhole* (Erskine, Moursund, & Trautmann, 1999). This visual representation shows “all the facets of a therapy of contact-in-relationship together, in dynamic relationship” (p. 159). A therapist can use the keyhole diagram to identify the patient’s developmental level through countertransference (Erskine, 1991) and, as a result, work most effectively.

The case study of Stella presented in this article offers an example of true therapeutic love, which promoted the healing of one of the most traumatized patients with whom I have worked. The study demonstrates the transformative

power of contact in relationship and shows that the therapist's methods (the how) and actions (the what) lead to change in the patient.

In the first section, I recount the development of my therapeutic relationship with Stella, particularly the relational processes that promoted the (slow) emergence of her traumatic history as well as her vulnerabilities. I describe the settings, contracts, and difficulties in the development of the therapeutic relationship and how I handled my failures in that relationship. In the second section, I offer some clinical and methodological reflections on Stella's script system (Erskine, 1980), which allowed Stella to self-stabilize her deepest forms of vulnerability. I also introduce the major relational processes that promoted the integration of Stella's self, the interventions that were most effective with her, and the successful implementation of some theoretical and methodological models that are coherent with IP theories.

My conclusions emphasize what I learned about the processes that promote psychological change and about the therapist's responsibility for establishing an authentic relationship with the patient. Such a relationship needs to be coconstructed (Stolorow & Atwood, 1992; Stolorow, Atwood, & Brandchaft, 1994; Stolorow, Brandchaft, Atwood, Fosshage, & Lachmann, 1999), deeply human, and constantly evolving.

Beginning and Development of the Therapeutic Relationship

It was a warm March morning when I received an unexpected call. "Hello? Isabella? This is Stella. I have called because I would like to do therapy with you." I was surprised by the determination I sensed in those words. Stella was part of a group of couples from a distant city where I used to hold training sessions. However, I had not visited there for more than 2 years and explained to Stella that I had stopped working there long before. Without hesitation, she answered, "Yes, I know you have not been here for 2 years, but I also know you hold sessions on Skype." Once again, her determination caught me unaware. After explaining to her how difficult it is to do therapy in that way, I felt that I had to have at least one meeting with her to help her find a therapist in her city.

During our first online meeting, Stella told me that she had been experiencing a period of deep confusion. She told me her life story, which was marked by physical and sexual violence that had started before she was 3 years old. At the time of our conversation, Stella was 40, the third of four daughters, and married with five children. She was feeling profoundly inadequate as a mother, was suffering from various diseases, and had miraculously survived a heart attack after the birth of her last daughter. Stella timidly revealed that she had suicidal fantasies. She told me about arguments with her husband that often culminated in screaming

and beatings that she passively endured. She told me that she had previously done therapy at a state-owned counseling center. However, she was never able to speak in front of “those psychologists with a stern look”; they made her “freeze.” I asked her what had made her think of me as her therapist, and she replied, “Your voice, your kind manner, your sensitivity, and your great calm. I know you are talented, but I felt good because of the way you looked at me and smiled first!”

I faced an ethical issue: Could I send a suffering person who had just found the relational style she needed to another professional? My body-centered countertransference allowed me to understand that Stella was a little girl, perhaps about 3 years old, abandoned and lost, and she was trying to cling to me with all her strength. This child was vital, sensitive, intuitive, and had a bundle of unmet needs. How could I refuse her request for help? How would she take my refusal? Too many questions came to my mind.

On the one hand, theories on therapeutic love were throwing me a challenge. Indeed, I was frightened by the high level of flexibility, engagement, and creativity that I felt were necessary to work with Stella. I felt called, like never before, to express in practice the consistency existing between my values and the philosophical principles of IP. I needed to find a channel that would allow me to respect Stella completely and, at the same time, respect myself. Could I do this? I did not know for sure.

On the other hand, I could feel that the little girl needed someone to trust. Therefore, I decided to be her therapist.

Exploring Stella’s World of Confusion

In the beginning, Stella and I agreed to meet once a week. She would travel to Rome once a month to see me in person, and for the remaining sessions, we would use Skype. In this phase, it was important for me to understand what kind of contact we could establish; later, we could start meeting twice a week. Stella began to come to Rome as agreed, always dressed—or rather covered—in her dark baggy clothes and armored in her excess weight. She did so notwithstanding her depression, shame, and sense of failure.

In those first months, I began to understand that Stella’s most neglected need was for security (Erskine & Trautmann, 1993/1997b; Erskine et al., 1999). Therefore, I offered her a safe space from the beginning, one in which she could be in contact with herself and with me in a way that was sustainable for her. She was highly adaptive, which was challenging for me and probably the hardest aspect of my work with her because it was almost impossible to detect. I had to pay attention to any tiny signal that could help me identify her interruption to internal and external contact. I also took the opportunity to repair my failures in the

therapeutic relationship (Erskine, 2011) by working on Stella's need to be respected, namely, her need for security. This approach acted as a balm for Stella, as powerful as unexpected.

Stella and I worked for several months on reconstructing the fragments of her story of sexual harassment and abuse. At first, the perpetrator seemed to be a 12-year-old boy who was partly related to Stella. Later, we discovered that it was a small group of youngsters who had engaged in rituals of sexual harassment with children. These rituals involved boys and girls between ages 3 and 10 who lived in the same district as Stella. She felt guilty for failing to escape and defend herself better as well as for being unable to protect her little sisters, who were also involved in the rituals.

It took a long time for me to recognize Stella's neglected needs. Much work was needed to normalize her terror, which had caused significant immobilization (Erskine, 1993; Erskine & Trautmann, 1996/1997a; Fraiberg, 1982a, 1982b; van der Kolk, 2015). My work was characterized by a good deal of interposition whereby I proactively interposed myself between Stella's Parent and Child ego states (Erskine, 2015, p. 256). When performed effectively, interposition counters the patient's "intrapsychic influence," and as a result, Stella began perceiving me as fully protective of her. Only then did she realize that she was too young to defend herself. "It was normal that no one would defend me. I only knew that I had to obey, stay there, under his body, and wait for him to finish and go away. I was not aware that he was stronger than me. I never thought about it. Now that I think about it, I truly wonder how this could be all my fault!" As she began to allow herself to feel and think, Stella's eyes became brighter, her shoulders relaxed, and she breathed deeper: Her body was alive, even for a short time.

Some fortunate coincidences in those first months of therapy facilitated the development of awareness and proactivity in Stella. The first was that Bianca, one of Stella's sisters, began therapy as well. Stella had told me about her sense of guilt toward Bianca and how Stella felt unable to relieve her psychotic sister's anxiety or to be close to and help her. I normalized her feelings and encouraged Stella to go to a mental health center with Bianca, where she was able to find a good psychiatrist to begin taking care of Bianca. Stella felt reassured and decided, with great relief, to set new boundaries in the relationship with her sister. When they met, she would enjoy their time together, but then she would let the psychiatrist take control of the rest.

A second fortunate coincidence was that the Red Cross opened an antiviolence center for women in the city where Stella lived. The psychologist in charge promoted creative workshops for abused women and invited Stella and her sisters to join. During the workshops, Stella and her sisters had to represent their traumatic experiences through drawings. The workshops allowed them to tell each

other their stories of abuse, which until then they had kept secret. By doing so, the sisters validated each other's story: "It was true! It wasn't just a nightmare!" Stella said to me one day.

A few months into the therapy, I asked Stella how she felt about our Skype sessions. Her answer was, "They're all right. There's a screen between us, and that makes me feel quite calm. I feel great!" "Of course," I thought, "she has experienced extreme violations. Probably the screen offers her shelter, a boundary she cannot set by herself, one that she did not even think she needed for her entire life." My later inquiry confirmed that assumption: She was afraid of being dependent on someone, even though what she wanted most was to depend on me. She needed to find someone she could trust (Bowlby, 1988; Erskine, 2009).

Stella's ambivalence was intense. Through withdrawal and negation, Stella had attenuated the chasm of loneliness and abandonment for her entire life. She had relieved the pain of having no one she could trust. The laptop screen was helping us establish a first, safe contact in relationship (Erskine, 2001b). Our initial agreement was working.

Stella's Story of Trauma and the Development of the Therapeutic Relationship

Childhood

Slowly, Stella started recalling in fragments episodes from her dramatic story of sexual, physical, and psychological abuse inside and outside her family of origin. Stella's mother was depressed and narcissistic. She took little care of her four daughters, barely remembering to feed and dress them. Often, she spent time doing her make-up and preparing to welcome a man into the house. She encouraged her little daughters to be open to any sexual contact with such men. The man would pay them a small amount of money after the "contact" ended. Stella was ashamed of telling me this episode and could not remember what kind of contact it was. Still, she said she remembered this event as another profound humiliation (Bromberg, 1998/2001).

However, Stella remembered some more significant events. A 12-year-old boy sexually harassed her at her grandmother's house beginning when she was 3 years old. The sexual ritual was always the same. By blackmailing her, the boy forced Stella to go to the restroom every time the hands of the clock struck a certain hour. Once Stella was in the restroom, he would join her, make her lie down, then lie on top of her. "He moved, he touched me, but I did not want him to. ... I waited

until it was over, and I came home with my dress dirty, but my mother never looked at me. If I talked to my mother about it, she would tell me that it was my fault.” For this reason, Stella made some script decisions (Erskine, 1980, 2010; O’Reilly-Knapp & Erskine, 2010) and adhered to them. As a result, she decided to never say a word about any event or person: “I felt like I was dead inside” she told me.

Stella also decided to stand between her father and her sisters. Stella’s dad lacked empathy, just as her mother did. He was judgmental, violent—both physically and psychologically—and ready to punish his daughters for no valid reason. His painful and sadistic punishments varied every evening, depending on what Stella’s mother told him about their daughters’ behavior during the day. Most of the time, Stella was the one who took the blame because she did not want to see her sisters suffer.

In such situations, Stella relied on dissociation, which Schore (2003b, p. 110) defined as the last resort of the child to protect himself or herself, a way to escape reality when it becomes too traumatic. The child stops working on interpersonal relationships and just focuses on himself or herself. Dissociation protected Stella from a desperate existence, unable as she was to bear the pain of her father’s cruel parenting. “When I felt bad, I would fly with my imagination. I imagined being on the ceiling or in my world of fantasy. That world was beautiful. I was happy, and nothing bothered me,” she said to me.

The self-portrait in Figure 2 depicts Stella’s experience of herself at the beginning of our therapy. Completely alone, she was living in a bubble, and her soul was full of bleeding wounds. This space served to protect her (O’Reilly-Knapp, 2001a). I was surprised by her trust in me when she showed me this picture, but I believe it was possible only because of her intelligence. Her intelligence also allowed her to focus on the painful realities of her story. I committed to expressing my support through attunement to affect and rhythm. I had managed to establish contact with her through a sympathetic look and a reassuring tone of voice (Erskine, 2011). These elements played a significant role in Stella’s therapy.



Figure 2. In Front of the Mirror

Adolescence

During adolescence, Stella's suffering reached its climax. She hated her body and mind and thought she suffered from an impairment because she could not communicate effectively. Even at school, her life was hard. She could not concentrate in the classroom or when teachers asked questions or while taking oral exams. Her professors believed she was absentminded and distracted. Her mother accused her of looking like a fool. Stella always felt guilty because of her learning difficulties; she believed she was stupid.

We worked a long time to replace this script belief (Erskine, 1980, 2010; O'Reilly-Knapp & Erskine, 2010) with other explanations as to why her mother so despised her. We also worked on Stella's maternal and paternal introjects (Erskine, 1988, 2010), with which she had unconsciously merged. A good deal of the preparatory work I did with her was to normalize those difficulties, delicately inquiring into what had been happening inside her while she sat in the classroom and what all that meant to her (Erskine & Trautmann, 1996/1997a). In addition, a careful and attuned inquiry into the life stories of Stella's mother and father (Erskine, 2011; Erskine & Trautmann, 1996/1997a) helped her to understand different perspectives on why her parents had been so inadequate and punitive.

Meanwhile, I continued to name and validate Stella's relational needs (Erskine & Trautmann, 1996/1997a). I often took on a parental function, offering the necessary mirroring to her suffering and responding sensitively to what had happened to her at school (Kohut, 1971, 1977). I always had in mind that abandoned little girl and was committed to offering her the experience that there

was now someone there for her who understood her position and needs. I was always ready to intervene to protect her. This kind of intervention, generally of interposition (Erskine, 2010), worked as a solvent to Stella's shame (Erskine, 1994).

Stella rapidly realized that her difficulties in class—especially when she had to answer questions—were caused by her father's violence, judgment, and punishment. She realized that at school she had continued to confirm her initial script decision (Erskine, 2010) not to talk to anyone. More deeply, Stella wanted to stop thinking and feeling. Situation by situation, I helped Stella put words to her thoughts and feelings from when she was a little girl at school. She told me that she had always wanted to say those words but that she had never found the right ones.

These sessions often ended with Stella hugging me intensely, putting her arms around my neck, kissing me on the cheek, and thanking me with a radiant look. I had established contact with the little child affected by a deep fixation (Erskine, 1988, 2010) dating back to her early years. I had established contact with the tender child who had never had someone who understood her and put words to her feelings, thoughts, or needs. Stella had never had someone to thank. Therefore, I assumed—and later found evidence—that her outpouring of love was her way of saying, "Thank you. You understand!" It was her way to demonstrate her relational need to express love.

Two Key Symptoms: Self-Harming Behaviors and Nightmares

We worked a significant amount on the fact that Stella often cut herself with a razor blade, a habit that made her scared and ashamed. She could not understand why she did it and spent a good deal of time accusing herself. A historical and phenomenological inquiry showed that Stella cut herself at times of high emotional tension, especially when she was being criticized or asked to run demanding errands for her mother or husband. Locked in anger and sadness, Stella became used to the fact that she was not able to react, explain, or ask anything. Cutting was her strategy for self-stabilizing (Erskine, 2010): "Through cutting, I release some tension," she said.

I worked to normalize Stella's self-harm and to help her to understand its function. Within our validating and supportive relationship, we normalized and recognized her suffering, which she had long denied. The normalization and recognition of her suffering helped Stella cope with her past. She stopped feeling so overwhelmed and began recognizing and understanding her deep emotions and unsatisfied needs (Erskine & Trautmann, 1996/1997a). As Stella learned how

to accept and express her experiences in our relationship, she diminished cutting herself until she stopped completely.

In the same way, we started working on Stella's dreams. Wounded and mangled bodies populated her dreams, which also involved phalluses entering her mouth and kinking around her body like snakes. There were also broken roads, lost children, and children who were born and later died. Containing, recognizing, and linking Stella's anguish to the traumatic experiences of her present and past was a relevant aspect of the work of mentalization (Fonagy, Gergely, Jurist, & Target, 2002), which I approached from an intersubjective perspective (Stolorow & Atwood, 1992; Stolorow et al., 1994). I rarely interpreted Stella's dreams, preferring instead to complete the inquiry process: She herself would lead me to her most profound wounds, isolation, and anxiety and to where they had originated. For Stella, such an approach was a path toward recovery from the sense of neglect and abandonment that she had constantly experienced.

A few months into the therapy, Stella told me that she had confided to one of her friends, a priest, that she liked to draw. She had a good deal of talent, which had been recognized by a professor at school. However, during adolescence, her parents had discouraged her and pushed her to slow down, against her teacher's opinion. The priest—a man rich in intuition—commissioned her to decorate a small chapel in the parish church. I was enthusiastic about the news. A vital aspect of Stella's personality had emerged (as I will describe later) and would eventually become a fundamental resource for her.

The Contract

What did our contract entail? We agreed on reconstructing her forgotten, unconscious, and untold history. When we began, her narrative was disorganized and her inner world was full of interruptions to contact in relationship.

For a long time, we followed a step-by-step or transaction-by-transaction contract. Normalization was a significant part of the process. I combined normalization with my respectful, balanced, and loving presence. Particularly for the first 2 years of the therapy, my presence aimed to help Stella understand that she was not guilty. Rather, her abusers were, and they had to feel ashamed.

Slowly, Stella became aware of the truth to the point that after a year-and-a-half of therapy, she decided to report her rapist to the police. This decision marked an important step toward Stella's integration of her self. Her dissociation slowly gave way to scraps of rage, which until then had remained unconscious and embodied. Because Stella's traumatic experiences had begun at a preverbal age,

she was not able to express trauma-related feelings verbally. Moreover, her script decision to stop talking also further paralyzed her.

When I offered her respect, protection, and reassurance, I was taking on myself the psychological functions of the self—that is, predictability, identity, continuity, and stability (Erskine, 2001a)—so that Stella could feel safe enough to say a few words. The drawing in Figure 3, which Stella completed about a year after the beginning of her therapy, shows her changes well, especially when compared to Figure 2. Stella is no longer alone inside her bubble, although she is still ambivalent when relying on the relationship with me, and visible wounds are still present on her body.



Figure 3. Reliance

“Go slowly, please!” Stella would urge me every time I lost my attunement to her rhythm because of my enthusiasm. At those moments, I was going faster than she could tolerate, losing the affective and rhythmic attunement that was fundamental in order for Stella to stay in contact with her needs and emotions (Erskine, 2011). Every time I pushed Stella to take another step, she would return the next session asking me in her little girl voice, “Do you love me?” She would explain that her doubt arose because she had not been able to take the step I was encouraging. It became clear that behavioral specifications were not effective with Stella. Indeed, she would entrench to her loyalty to her maternal and paternal introjections and the terrifying expectancy coming from their criticisms and punishments. These failures in the therapeutic relationship were important to me. I would apologize because I was sorry for being unable to work at the rhythm she needed and looking to repair my failures. In these moments, Stella looked at me with her eyes wide: No one had ever apologized to her before, nor had they tried

to fix their failures (Erskine, 2011). Such interventions contributed to enhancing Stella's awareness of her value and dignity.

A New Setting and Some Delicate Aspects of the Therapeutic Relationship

Two years after beginning Stella's therapy, I was able to reorganize my schedule in order to meet her in person twice a week. She welcomed this change with enthusiasm because she felt ready for it. Our contact became even more intense and intimate. The computer screen had become a useless defense for her, and, as she told me, she no longer needed it.

During the first 4 years of the therapy, we worked on the need for protection and depending on someone (Figure 4) by relying on interposition and supportive regressive therapy (O'Reilly-Knapp & Erskine, 2003). When Stella rested her head in my lap, a position she loved and often chose, she would often be at odds with herself. "Can we do this?" she would ask. "It makes me feel like criticizing myself. I think that I do not need it, I am acting like a little girl. ... Well, since this kind of contact makes me feel good, that's it!" The regressive work (Erskine, 2008) of leaning toward me and enjoying my warm embrace always made her extremely happy. She had finally found a tender mother.



Figure 4. The Healing Process

Some more delicate aspects also affected the development of our therapeutic relationship. For a long time, Stella struggled to remember our appointment time. She did not use an scheduling agenda because having an appointment meant looking at a clock, and, because of her history, that was something terrible for her.

Relying on the keyhole of methods (Erskine & Trautmann, 1996/1997a) (as described earlier)—and especially on interposition, normalization, and affective and rhythmic attunement—was crucial in facilitating Stella in separating the face of her rapist from mine and the meaning of those appointments from that of ours.

Other signs of Stella's transference would often occur during summer, Christmas, and Easter holidays. Although she knew that she could call me when she wanted to, making demands was new for her, and she often denied herself the possibility. Thus, I began to take the initiative and occasionally text her when I was on vacation (Erskine, 1991). It was my way of letting her know that she was on my mind (Fonagy et al., 2002), even if we were far away from each other and could not meet. Her joy on receiving those texts was moving. In an intermediate phase, Stella began to ask for help indirectly. For example, she would text me asking how I was feeling. In those moments, I would immediately understand her request for help, which we then addressed together.

For a long time, another significant moment in transference terms occurred right before starting the session. I noticed that every time Stella entered the waiting room, she would give me a quick glance, as if she had to check on what to expect from me that day. She later explained that it was her way of understanding her mother's feelings before they could cause her trouble. My inquiry often revived childhood memories in which Stella was terrified by her mother's glares and threats. Those memories were, in some cases, an opportunity to work on maternal introjections (Erskine, 2008).

Another delicate point in our therapeutic relationship was Stella's contact with her anger. The respectful relationship we had built together—a safe harbor for her—slowly allowed Stella to begin recognizing her anger without being afraid of it. It was challenging for me to understand the fear behind her blank face and still body. I eventually discovered that an exercise of muscle activation (Levine, 2010) was particularly pleasant and feasible for her.

One day, Stella looked terrified and paralyzed. I proposed that we performed a simple exercise that would have required her to slightly move an arm and a leg as a way to search for and perceive the strength inside her arm and foot. Stella slowly started lifting her leg; then her pushes became gradually stronger to the point where she started kicking. In her mind, she was kicking her tormentor and her mother while I was helping her put words to her anger. Our contact was genuine and occurred thanks to the long preparation period we had shared together. Stella's energy was flowing, and I was there as a participant witness.

At the end of the work, Stella said that she was surprised by the outburst of strength, which she liked feeling. She added that she had felt my words were helpful, words that she had not been able to say because she was too small and frightened. That session and similar ones resulted in several behavioral changes

related to the definition of her self and the establishment and regulation of boundaries with intrusive people.

A Special Resource: Stella's Drawings

In the beginning, I often wondered what prevented Stella from either going insane or committing suicide given that she was dealing with such severe violence and chronic neglect. As a result, I assumed that two factors played a vital role in Stella's story: the presence of a particular aunt in her life and Stella's passion for the fine arts.

After a few years of therapy, Stella remembered the presence of her aunt, who was affectionate and caring. The aunt had taken care of Stella for months when she was about a year old when Stella's mother had been hospitalized because of a depressive crisis. The later death of her aunt deeply saddened Stella, so we worked on coping with that loss. Stella became more aware of how loving and supportive her aunt had been and how nurturing the relationship had been for Stella. Indeed, the aunt had loved Stella and had taught her many good habits, which Stella unconsciously followed her whole life.

Second, I believe that Stella's love and talent for the fine arts—especially painting and drawing—were other important resources for her. Although her parents always opposed her talent, Stella kept drawing in secret until the day her friend commissioned her to decorate the small chapel. Stella threw herself into that work, feeling both amazed and scared of the criticism she might have received from others and of being incapable. When she was close to completing the church decorations, she invited me to go and see them. I gladly accepted because I knew how important my attunement to her need for validation would be. This resulted in Stella's decision to attend an advanced course in religious painting so she could begin teaching it. Through painting, Stella could establish contact with her inner self and define herself. Her love for the fine arts often made me think of the *fundamental dynamic pentad* described by Stern (2010/2011, p. 6). It represents every "vital experience," namely, a person's experience of being alive, that one may encounter. "Movement, time, force, space, and intention" are the five dimensions of "the vital experience" and constitute a unique gestalt (p. 6). The modalities of the vital experience are many and varied, but most are related to the arts. Painting was Stella's vital experience, which she always contrasted with her immobilization and sense of being dead inside.

Stella relied on self-portraiture during key moments in her healing process. She would sometimes bring to a session a folder containing a drawing of her stage of self-development and our relationship (see Figures 2, 3, 4, and 5). The more

progress she made in therapy, the more her artistic initiatives expanded and the more confident and autonomous she grew.

A couple of years ago, Stella started a session by telling me that she had enrolled at university: "I have some huge news! I enrolled at the Academy of Fine Arts!" I was surprised and moved by her decision because she had not talked to me about it beforehand. I asked her why she had not enrolled in university before. She said that she had prioritized dealing with more serious issues, and she stressed with a smile that she could finally enjoy her achievement and stop focusing on solving her problems.

The Goals We Achieved and the One Yet to Be Achieved

At the time of this writing, Stella was in her junior year at the Academy of Fine Arts, scoring the highest marks in almost all of her freshman exams. She holds training and workshops for art students and exhibits her work in a small gallery in her hometown, thus profiting from her art. Over the previous 2 years, she faced predictable problems with two of her five children. Stella stopped cutting herself 3 years ago and has established many healthy boundaries with relatives and friends. She is successfully supporting the growth of her children and is deeply committed to her professional development. A year ago we began meeting once a week.

Figure 5 shows Stella's current self-portrait. She has placed herself at the center, her arms raised and her body leaning forward toward the future. Behind her, she drew her children, whom she wants to protect. In front of her, Stella drew me as someone who provided her with guidance and helped her to take a healthy direction. I was surprised that she portrayed me with thick, long hair, exactly as it was when she met me. Today, my hair is not the same, but Stella's imprinting of me is evident in the drawing.



Figure 5. Journey of the Self

We have not yet managed to untangle every knot for Stella. She and her husband began couples therapy 2 years ago. Unfortunately, Stella's husband interrupted the therapy only a few months into it. Right after his decision to stop therapy, a drama teacher sexually harassed their 16-year-old daughter, Maria. The teacher, 20 years older than Maria, had harassed her at a theater school, and he is now under investigation on charges of pedophilia. The investigation began when Stella reported what happened to the police and forced her husband to do the same. He was reluctant to do so and thought the abuse was Maria's fault. He considered his daughter to be lacking moral values and a sense of responsibility and failed to take action to protect her. As a result, Stella was the one fighting to protect her daughter, regardless of her husband's position on the matter.

Today Stella is well aware of her need to share some parental functions with her husband. In the last 2 years, we have often worked on this awareness as well as on Stella's needs as a woman in the couple.

After what happened to Maria, Stella's husband decided to do therapy individually. This decision came after several people put him under pressure, including the police, counselors, and his family. Today, Stella has stopped accepting her husband's discouraging and provocative attitudes toward her. Consequently, she is seriously thinking about divorce. Her husband does not accept Stella's changes: He would like her to drop out of the university and return to being the passive, submissive wife she used to be. We still need to work on this theme in order to complete the decommissioning of the introjected Parent (Erskine, 2008).

Some Theoretical-Methodological Considerations

Stella's Script and Her Vulnerabilities

Shame was an omnipresent experience in Stella's life along with depression, a sense of impotence, self-devaluation, and passivity. Surrender was Stella's only defense (Fraiberg, 1982a, 1982b). We understand surrender as an interruption in the contact between a person and his or her pain, something that is functional for survival. Stella built and reinforced this strategy beginning in early childhood. Stella's body looked "dead," abandoned, and intangible (van der Kolk, 2015). I often wondered how to reach that little girl. On the one hand, she trusted me; on the other, she built high walls with everyone, including me because she did not want to be violated again (Erskine, 2001b).

For a long time, Stella did not manage to protect herself from physical and verbal violence whether it came from her mother, father, friends, or husband. She was completely exposed to violence. As with every abused child, when Stella had to explain the reason for all that violence, she would blame herself: "It's my fault. I had to defend myself!" she would say. The pain she repressed in her body resulted in a series of diseases: a heart attack, obesity, hip joint problems, fibromyalgia, rheumatoid arthritis, and so on. Despite being tormented, her body was full of vitality, which Stella attributed to her love for her children.

Stella's family never satisfied her relational needs. As a child, she rarely experienced protection from a trustworthy adult, and her unsatisfied need for security prevented her from satisfying other needs as well. This situation was worsened by the fact that Stella was 3 years old when the abuse began, and she had not yet fully developed her speaking ability. Consequently, Stella protected herself by interrupting any contact between her, her early memories, and her frustration coming from unsatisfied needs (Erskine, 2008). She implemented freezing and withdrawal as extreme defenses from such overwhelming pain. In attempting to stabilize these tensions, the "cutting-myself-to-feel-better" solution clearly showed the absence of anyone Stella could trust. Meanwhile, she secretly developed a sense of pseudoautonomy that covered her sense of shame, profound impotence, and inadequacy. By this sense of pseudoautonomy, Stella perceived herself as "capable" of protecting her sisters from her parents (Erskine, 1994).

All these elements—Stella's forms of vulnerability expressed in all the domains of her personality (Erskine & Trautmann, 1993/1997b)—merged into her script system (Erskine, 1980; O'Reilly-Knapp & Erskine, 2010), which rested on beliefs such as "nobody sees me, nobody thinks of me, I'm worthless" and on others such as "I'm strong and invulnerable." Among her script decisions were "If I

keep quiet, I will escape,” “I won’t cry,” “I’ll save everyone,” “I’ll never talk to anyone to protect my mom and dad,” and “I will imagine a parallel world where everything is perfect.” It was becoming clearer that a powerful self-stabilizing function characterized Stella’s script system, one that was especially related to her feelings of shame, powerlessness, and sense of guilt, all of which overwhelmed her.

Effective Therapeutic Interventions and Integration with Other Theoretical-Methodological Models

Continuously processing my countertransference allowed me to recognize and attune to Stella’s often variable developmental ages and unconscious relational needs. I was particularly prone to bodily countertransference because many of Stella’s traumas occurred when she was preverbal. However, I was able to adjust our work depending on the developmental stage Stella was experiencing as well as provide answers and put words to her feelings. Such work varied depending on the trauma we were working on and when it had occurred.

I relied extensively on affective regulation, particularly through my nonverbal communication (eye contact, tone of voice, rhythmic attunement), my reassuring attitude, and my ability to hold Stella in my mind and to verbalize her most overwhelming emotions (Erskine & Trautmann, 1996/1997a, 1993/1997b; Fonagy et al., 2002). Stella managed to calm down, be reassured, and stay in touch with reality thanks to relational modalities such as containing, calming, thinking together, remaining optimistic, and infusing hope. We gradually rebuilt reality thanks to the slow reemergence of preverbal and subconscious memories (Erskine, 2008; Winnicott, 1911/1970). Facing a destructive introjection, I offered Stella a relational experience that was sufficiently different, that is, the experience of a “good-enough mother” (Winnicott, 1970, pp. 183–184).

I also relied on therapeutic interventions such as interposition, the supportive of regressive therapy, therapy with the introjection, and body awareness activities (O’Reilly-Knapp & Erskine, 2003). These effectively promoted the integration of the self and the “personality domains” (Erskine & Trautmann, 1993/1997b, pp. 86–89) of Stella. However, our work was effective thanks primarily to my continuous affective and rhythmic attunement, some delicate historical and phenomenological inquiry, frequent normalization, and my therapeutic involvement. Above all, I was present, an empathic witness (Levine, 2010) to what Stella experienced moment by moment (Stern, 2004, 2010/2011). Even the psychological functions (Erskine, 2001a) that I gradually took on helped Stella build and consolidate her secure attachment (Bowlby, 1988) in her relationship with me. Session after session, we

reestablished contact between her experiences and her unconscious and painful memories.

A couple of years ago, I finally received validation about the relationship Stella and I had built. I understood that I had become a secure base for her. During a session, I proposed that Stella engage in one of the exercises developed by Levine (2010) in his somatic experiencing method. We tried it to learn how she could overcome the fear of immobilization when she wanted to be active and assertive. I want to emphasize that Stella became increasingly secure in staying in contact with her anger and expressing it openly thanks to the work of those years.

We built together methods, strategies, and moments that Stella relied on to express herself through her body and to give words to her anger. It was exciting to see her sense of security becoming stronger as a result of alternating moments in sessions in which we focused on her fear of expressing herself in front of those who disqualified her and then daring to kick or punch a pillow.

As the therapy progressed, Stella showed impressive sensitivity and resilience. I remain convinced that one of her great sources of energy and positivity was her passion for art. Despite the seriousness of the traumas she had suffered since childhood, she had managed to preserve her mental health. She stayed active, intuitive, and proactive. Her vital energy, which surprised and engaged me, became particularly intense when she spoke about her passion for painting, drawing, and sculpting. I would feel a vital energy permeating her body and transforming her, making her eyes and smile brighter.

Stella knew only too well how immobilization characterized her relationships and a feeling of death permeated her life. From reading Stern (2010/2011), I understood that Stella had found a creative and powerful solution that allowed her to survive the loss of contact in relationship. She desperately needed to survive her limiting script system, the way it manifested in her life, and its consequences. Thus, when it came to explaining Stella's vital energy, which made her alive and living in front of others, I felt that Stern's question on vital energy and how it translated into the real world reflected my own questions and feelings (p. 5). When introducing the fundamental dynamic pentad, Stern explained how vitality, relationship, and intersubjectivity are strictly connected and interdependent. Whatever happens always happens in terms of five dimensions: movement, space, force (intensity), time (duration, rhythm), and intention (direction, destination). Each of these dimensions is indivisible from the other four.

One of Stella's vital dynamic forms was undoubtedly drawing. It allowed her to experience movement, intentionality, and dynamism. When she drew, all of Stern's vital forms were present as described in the fundamental dynamic pentad. For example, drawing constituted a vital space for Stella. It allowed her to experience movement, intentionality, and dynamism. It was a powerful strategy by

which Stella could feel alive because it addressed both her preverbal and verbal stages of life. Even though in drawing she was “building a relationship” only with some paper, she was doing it her own way. Drawing allowed Stella to express intentionality, agency, and rhythm (Stern, 1985). For her, this meant being alive again, and her regained vitality resulted in the gradual emergence of her sense of self. If she did not lose contact with her sense of self, it was thanks to art, an indispensable part of her life. “Art is life,” she would say.

The most significant part of my work with Stella involved paying attention to my closeness or distance from her as well as my tone of voice, gaze, smile, rhythm, intensity, and intentionality. It is thus possible to view my approach through the lense of the fundamental dynamic pentad and its vital forms. Vital forms go beyond contents and provide the child with a primary relational experience. The child’s relationship with the external world depends on whether an adult provides the child with stabilization and affective regulation. This depends on the way the adult expresses himself or herself at the level of the vital forms, which also constitute the background of the pentad. Humans write over the surface of the pentad every word and content of communication among them.

My intention with Stella was to build a relationship that permanently focused on her relational needs. Our communications worked simultaneously on two levels: a verbal (or social) level and a nonverbal (or psychological) one. The former relied on her words, which Stella was not directly saying to me—namely, one of her needs. She wished I could understand her needs from her nonverbal communication, especially her tone of voice. I would understand her and act or speak according to the relational need she was trying to express. The relationship between us rested on this nonverbal communication. She had the chance to experience with me the healthy kind of communication that she did not have with her mother.

Conclusions

My approach in therapy rests on a view of the person that is deeply relational and on philosophical principles that consider psychopathology to be the result of failing to tune in to a person’s developmental needs, on the relationship as the basic motivation of behavior, and on contact as the way to satisfy a person’s need to relate. From my experience with Stella, I learned that the way the therapist relates with a patient is more important than what the therapist says or does. Indeed, what promoted Stella’s healing began with my calm, my tone of voice, and my gaze. My nonverbal communication is the result of constant work on myself, which means continuously studying, updating, monitoring, and training about

contact in relationship. The methods (the keyhole of methods) resulting from IP principles are deeply interconnected with the theories of motivation and of personality compatible with a relational view of the individual (Erskine & Trautmann, 1996/1997a). The findings of neuroscience (Schore, 2003a, 2003b; Siegel, 1999) confirm and reinforce this view of the nature of the person—and of the human mind—as essentially relational.

Stella also taught me that respect should be the guiding principle of therapy because it restores the self permanently. I understand respect to be careful of the individual's inner and outer world and his or her points of contact with these two worlds. This also entails understanding the extent to which the person can maintain contact in relationship in the here and now. This helps avoid experiences of retraumatization and/or hyperadaptation. I validate my assumption that the interruptions to contact in relationship—commonly known as defenses—are functional for survival; one cannot violate another person's defenses without reinforcing them or creating new ones. In Stella's case, she needed to test me again and again to make sure I respected her. Once she understood I respected her pace, rhythm, and difficulties, she gradually lowered her defenses, and I managed to be in contact with her pain.

A deep integration of the self encourages profound change. Integration results from a therapist's careful work of inquiry, attunement, and involvement with the patient. However, integration is ephemeral when the therapist does not strive to improve himself or herself continuously. Indeed, the greatest factor contributing to therapeutic success rests on the therapist's relational competence. Continued professional and personal training develops and fosters this competence: It is the therapist's capacity for authentic therapeutic love (O'Reilly-Knapp, 2001b). Moreover, competence is made up of knowledge of theories, technical ability, and personal ability. It is, above all, knowledge of how to be in relationship (Guarrella, 2013). A therapist who stops working on his or her personal growth is doomed to failure or, at best, to producing adaptations that will not last. Therapists who take care of themselves enjoy the success of their patients. They witness their patients' success as enthusiastically as a mother looks at her son smiling for his achievements after experiencing failure. No matter how many attempts, failures, and successes they had to experience, they shared each of those moments together with complicity, trust, and hope.

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