INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

volume thirteen • number two • fall 2014

EABP

EUROPEAN ASSOCIATION FOR BODY-PSYCHOTHERAPY

USABP

United States Association for Body Psychotherapy

International Body Psychotherapy Journal
The Art and Science of Somatic Praxis
(formerly US Association for Body Psychotherapy Journal)

The International Body Psychotherapy Journal (IBPJ) is a peer-reviewed, online journal, published twice a year in spring and fall. It is a collaborative publication of the United States Association for Body Psychotherapy (USABP) and the European Association for Body Psychotherapy (EABP). It is a continuation of the USABP Journal the first ten volumes of which can be ordered through the website http://www.ibpj.org/subscribe.php.
The Journal's mission is to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as to encourage an interdisciplinary exchange with related fields of clinical theory and practice through ongoing discussion.

Editor in Chief: Jacqueline A. Carleton, PhD
jacarletonphd@gmail.com
Managing Editor: Jill van der Aa
jill.vanderaa@eabp.org
Associate Editor: Diane Cai
dianecai@gmail.com
Submissions Editor: Rachel Vitale
rpv213@nyu.edu
German Editorial Committee: Elizabeth Marshall,
elizabeth.marshall@gmx.de

Production Team
Design/Layout: Ronald Jeans
Cover Design: Diana Houghton Whiting
Cover illustration: Dora Theodoropoulou

Correspondence Addresses
Editor: jacarletonphd@gmail.com

The IBPJ is available free online.
Print subscriptions: www.eabp.org/ibpj-subscribe.php
Printed single issue Members €17.50, Non-members €20
Yearly subscription: Members €30, Non-members €35
Two-year subscription: Members €55.00, Non-members €60.
Payment through bank transfer, American Express or PayPal.
Changes of address: secretariat@eabp.org
Advertising: jill.vanderaa@eabp.org

Translation The online Journal is published in the English language. Abstracts of articles are to be found on the IBPJ website in Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian and Spanish.
http://www.ibpj.org/archive.php
If an article originally written in another language has been accepted for publication in English, the full article may also be found in the original language.

NB The accuracy or premises of articles printed does not necessarily represent the official beliefs of the USABP, the EABP or their respective Boards of Directors.

ISSN 2169-4745 Printing, ISSN 2168-1279 Online

Publishers: USABP usabp@usabp.org www.usabp.org
EABP secretariat@eabp.org www.eabp.org
IBPJ www.ibpj.org

INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL THE ART AND SCIENCE OF SOMATIC PRAXIS

The Scene of the Crime: Traumatic Transference and Repetition as Seen Through Alfred Hitchcock's Marnie

Eric Wolterstorff, Ph.D. & Herbert Grassmann, PhD.

Received on 22/07/2013. Revised 120/1/2014

Abstract

This essay presents an integrated approach to treating traumatic transference dynamics. Our theory integrates findings from the family therapy literature, principally the contributions of Murray Bowen; new understandings about memory from the field of neuropsychology, most clearly expressed in the writings of James Grigsby; and insights into the behavior of the autonomic nervous systems of people after they have been stressed or traumatized, as modeled by Peter Levine. Our work integrates these three literatures into an approach to addressing the complex interpersonal dynamics that arise when psychotherapists work with clients who have experienced a particular class of traumas which we call "in-group traumas", which is to say, those clients who have a history of involvement in traumatic incidents in their families, schools, churches or other tightly knit groups. Because of the close and ongoing nature of relationships in these groups, memories of traumatic experiences in such environments can be more complex than memories of car accidents, surgeries, or even an attack by a stranger. We propose a way to conceptualize these memories of "in-group" traumas. To do so, we rely on five ideas: 1) It is useful to simplify people's behavior during a traumatic event into four roles: Savior, Victim, Bystander, Perpetrator. A single individual might play more than one role, even during the same event. 2) Individuals playing any of these four roles can develop posttraumatic symptoms. 3) Traumatic reenactment can be accounted for through the mechanism of projective identification. 4) During a traumatic event, we remember not so much what happened to us alone, but rather our subjective interpretation of the entire traumatic event itself; we remember the scene of the crime. 5) Healing from a complex relational trauma requires integrating all four posttraumatic roles and, through them, the whole of the traumatic event. Identifying with one of the roles and disidentifying with the others, as is usual, leaves clients with a superficial misinterpretation of what they actually remembered because, during the original traumatic event, they also remembered what they imagined at that moment to have been the experience of others present. To conclude, we describe the implications of this interpretation for clinical interventions. Throughout, we use a (fictional) case study accessible to any reader, Alfred Hitchcock's 1961 psychological thriller, *Marnie*.

Keywords: trauma, group dynamics, traumatic transference and countertransference, traumatic reenactment and projective identification, posttraumatic memory space, Alfred Hitchcock

International Body Psychotherapy Journal *The Art and Science of Somatic Praxis*
Volume 13, Number 2 autumn 2014 pp 29-43. *ISSN 2169-4745 Printing, ISSN 2168-1279 Online*

Marnie: A Story

The woman walks briskly down the train platform, a gold purse tucked up under her arm. Carrying a suitcase, she appears calm and confident. The scene switches to a small business, where the distraught owner is being interrogated by the police. Visibly upset, he indicates an open, empty safe. How could he have so misjudged his missing secretary? She seemed so proper and earnest. Later, the same woman, again seen from the back, stands in a hotel room, calmly sorting the contents of one suitcase into another, exchanging social security cards. She dyes her hair blonde. At last, we see her from the front, in her new outfit. Only later do we learn her identity, Marnie, the title character of Alfred Hitchcock's 1964 psychological thriller.[1]

In a famous interview, Hitchcock revealed to François Truffaut that making films was the only way he could work through his own anxiety (Truffaut, 1985). For our purposes, this is the key sentence of the interview because Hitchcock, like no other director, manipulates the anxiety of the film watcher. In Marnie he feeds us clues: a purse, a suitcase, a key. So it is for people with traumatic memories; we fixate on details: an image, a word, a smell. Watching *Marnie* we shift from detail to detail, with only a sense that somehow they will fit together. Hitchcock plays with our perspective. We are *observers*, caught up in a search for meaning, helpless to change what we see. We feel the mounting fear of the *victim*, trapped in our fates. We feel the impulse of a *savior* to resolve the tension.

Set against the protagonist of Marnie appears the character of Mark Rutland as the antagonist. The ambiguous casting of Sean Connery as Rutland is simultaneously unnerving and reassuring, as he is familiar to the audience as both a womanizer and a champion, in any case a man of action. He hunts Marnie and, step-by-step, acts both to capture and to heal her. To bring her close to him and to protect her from discovery by the police, he blackmails her into marrying him. She is terrified of any sexual relationship with him and attempts suicide. For the kleptomanic Marnie Edgard, bound to Rutland, it appears there is no escape from the web in which she is trapped.

Marnie begins as a cipher, giving us only clues as to her psyche: she panics when she focuses on the color red or during storms. She hides her other crimes, her past, her childhood, her profound early trauma, only to have it pulled from her, one revelation after another, by Rutland. As the film progresses, we learn more and more about her. Finally, we learn that many years before, Marnie's mother, Bernice, worked as a prostitute. When a sailor would come to visit, Bernice would wake and move her daughter, little Marnie, to free the bed. One night, when Bernice thought a sailor was going to molest Marnie, she hit him, causing him to fall on her. Marnie, only six years old and afraid for her mother, grabbed the fireplace poker and struck the fallen man repeatedly, killing him. As the film closes in the apartment near the docks with Rutland, Marnie and her mother, all is revealed and felt in full. Marnie's conflicted feelings toward Rutland seem to be resolved. As Marnie and Rutland drive away, the sky is clear above the docks and sea. The storm has passed.

[1] Marnie, with Tippi Hedren and Sean Connery playing the leads, is based on Winston Graham's book of the same name.

A Theory of Traumatic Transference[2]

As psychotherapists, we meet with clients who report stories that involve close relationships and violence. Because of the close relationships, these kinds of traumatic memories are often more complex than less relationally intimate traumas, such as most car accidents or surgeries or attacks by strangers. In this article, we propose a way to conceptualize memories of these kinds of familial[3] traumatic events — those that involve members of our family, school, neighborhood, club or community. Throughout, we use Marnie's story as illustration.

To deal with the memories of close or "familial" traumas, we will rely on five ideas. First, it is useful to simplify people's behavior during a traumatic event into four roles: those of Savior, Victim, Bystander, Perpetrator. Keep in mind that a single individual might play more than one role, even during the same event. Mark Rutland, for example, was both a Perpetrator (he blackmailed Marnie into marrying him and pressed her to reveal her past) and a Savior (he protected Marnie from the police, pressed her to reveal her personal history and misdeeds, and comforted and supported her as she integrated her traumatic past). Second, individuals playing *any* of those four roles can develop posttraumatic symptoms. Bernice was a Bystander to Marnie's murder of the sailor while here Marnie was the Perpetrator. Posttraumatic transference occurs because we remember others present at the traumatic scene. Both Marnie and her mother remember each other and the sailor. Third, traumatic reenactment can be accounted for through the mechanism of projective identification. This will be shown below through Marnie's behavior in the film. Fourth, we remember not so much what happened to us, but rather the traumatic event itself; we remember the scene of the crime. Finally, therefore, healing from a complex relational trauma requires integrating all four posttraumatic roles and, through them, the whole of the traumatic event.

Typically, we choose to identify with one of the roles, usually the role we actually played, and disidentify from the others. This leaves us with a superficial misinterpretation of what we actually remember, because we also remember what we imagined at that moment to have been the experience of the others present. This remembering of the whole scene occurs whether or not we want it.

Our traumatic memory stores our perception of the experience, including all four roles, regardless of which role(s) we played personally. Figure One represents this as "the memory space":

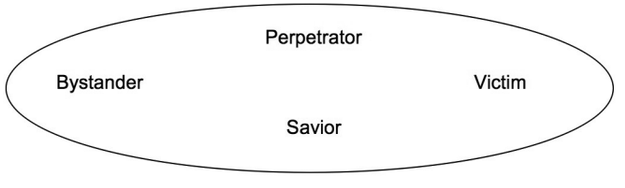


Figure 1: The Posttraumatic Memory Space, the "Scene of the Crime"

[2] The authors wrote this essay after a talk given at the European Association for Body Psychotherapy conference in Cambridge, September 2012. It expands on a five-page note that accompanied the talk, in which the authors introduced an understanding of traumatic transference stemming from family traumas, and of transferential and countertransferential dynamics in the therapeutic setting. As with the presentation, the notes and this essay are based on an integration of traditional transference and countertransference dynamics, neuropsychological research of the past twenty years about memory systems and attachment, and the traumatology literature. Fine-grained citations to these literatures are available in the first five chapters of Wolterstorff's dissertation, A Speculative Model of How Groups Respond to Threats, available at http://storffgroup.com/monograph.php. The intent of this essay is only to introduce the theoretical model underlying this particular approach.

[3] Or school, church or other "in-groups", in which we have been members for months or years.

Here are the five ideas in more depth:

1. Savior, victim, bystander, perpetrator. Traumatic events are remembered in a vivid, distorted fashion, in which the essential elements of the event are impressed in memory and persist over time. Meanwhile, secondary elements of the event decay, and are reinvented, progressively simplified and distorted through confabulation each time the event is recalled.

Traumatic memories contain physical sensations, the positions of the body, what was seen, and impulses, emotions, and thoughts from the moments of an event. Marnie's memories of her fateful night are associated with the sound of thunder (there was a storm that night) and the color red (of the dying sailor's blood).

If the people present at the scene of the trauma were part of our daily lives, we store the memories of each of them in an abbreviated, stylized form, as a Savior, Victim, Bystander or Perpetrator. We remember traumatic scenes in different ways, through different memory systems, which not only involve thoughts and feelings but also autonomic nervous system states, physical sensations, impulses and images. There is nothing magical about these four roles; they are shorthand categories into which we simplify what took place in a traumatic event. A different language or culture might split the Bystander role into Bystander-as-Victim (wanting but unable to help and watching in horror) and Bystander-as-Perpetrator (able to help but choosing not to) — and so on. For the purposes of therapy it does not matter how these roles are characterized by our language and culture. What is important is that they encompass and simplify the behavior of other actors in the traumatic event, like actors in a play: the hero, the bad guy, and so forth.

2. Traumatic transference. Although most of the trauma literature is devoted to the posttraumatic symptoms of Victims, each posttraumatic role is accompanied by symptoms. Saviors can express compassion fatigue. Saviors and Bystanders can suffer from survivor guilt, or observer trauma. The most severe posttraumatic dysfunctions (addiction, suicide and, perhaps, reenactment) occur with Perpetrators. Exposure to a traumatic event can engender posttraumatic symptoms in all those present.

After a trauma, people may act differently in relationships. They may experience greater difficulty in trusting others ("Are you going to hurt me?") or in defending themselves ("Please don't hurt me."). Helping people to regain the ability to trust and to set boundaries and defend themselves is often the task of the trauma therapist. Most trauma therapists are familiar with traumatic transference: "You'll save me" or "You understand because this happened to you, too" or "You just sit there and watch me suffer. You don't really care about me" or "I don't trust you." Marnie has difficulty trusting anyone. Bernice can only seem to love the little neighbor girl, who perhaps appears to her as Marnie was before the night of the murder.

Traumatic transference is possible because individuals remember what they imagine to have been the experience of the other people present at the traumatic scene. Just as we do in everyday interactions when we imagine the experience of others to create rapport, to understand, and to learn to predict their behavior; when dealing with trauma we also internalize what we perceive to have been the experience of the other people present at the scene of the trauma. We learn all of the behaviors that occurred: the behaviors of the Savior, Victim, Bystander and Perpetrator, regardless of which behavior we enacted ourselves. In doing so we remember these four different orientations toward the world; we learn in turn how the world appears when we are a Savior, a Victim, a Bystander and a Perpetrator, as well as the posttraumatic stance of each role.

When individuals are reminded of a traumatic event, they recall the traumatic scene, and try to fit the current scene into the frame of the past traumatic scene. As a six-year-old might imagine playing the prostitute, Marnie's scam with employers is to play the perfect employee, earnest, hard-working and attractive. In exchange, she "pays" herself by removing money from the company's safe, then goes on to change her identify, to prepare herself for her next client. This is the lens through which she experiences Rutland. Her frigidity protects her from more associations with the night of the murder (her mother's prostitution), but keeps her psyche partially frozen at its six-year-old emotional state, which keeps her emotionally immature and unable to integrate and heal the trauma.

As with Marnie, our projection of the past onto the present can be either helpful or harmful. Consider three variations of what might happen from the point of view of the Victim role. If we grew up in a home in which our father beat our mother and we find ourselves entering an intimate relationship, we may be reminded of our childhood and the potential for abuse. If, indeed, our potential partner has a history of becoming physically abusive in intimate relationships, our memories from the past are an advantage to us. (This may have helped Marnie avoid dangerous relationships before the period of her life we see in the film.) We are a step ahead of the game and can prepare ourselves to flee or otherwise protect ourselves. But, if our potential partner means us no harm, yet we act as if they do, our behavior can be seen as crazy or paranoid. We might refuse the relationship to our own greater isolation and loss. (An example is the scene in the movie in which Mark Rutland meant well and was good to Marnie but she could not reciprocate.) The most dangerous dynamic (for us), is when the person means us no harm, but has tendencies to violence. Our fearful behavior can provoke or, over time, entrain the other person to assault us. This occurs in a hundred small ways: We might avoid confrontation, allowing unpleasant interactions to fester. We might acquiesce to requests we would normally refuse. Our partner, in innocence, might keep pushing to find a mutually acceptable boundary. By not standing up for ourselves, we support an evermore imbalanced kind of interaction that can lead to a power imbalance, which may invite disrespect, thus increasing the potential for abuse. The entire time we might be aware of the dynamic but may not know how to extricate ourselves from the situation. We remember the interactions in the family we grew up in as the script of a play. This is the play we understand and that is our default interpretive lens. (Until the final scene, Marnie is unaware of how her trauma-script has shaped her life. Throughout the film, she searches out and recreates the scene of the crime, each time a danger to herself and those close to her.)

Just as in the Victim example above, the same dynamic can trigger us into the role of the Perpetrator, Savior or Bystander. If, when we were small, our parents struck us in anger, when we are later parents and angry, our childhood memory will be triggered and we can experience the impulse to take the Perpetrator role, to strike out and hit our child. (Marnie was only a child. Her mother was the prostitute, yet Marnie plays the role of the prostitute in her kleptomania.)

Or if, as children, we were part of a mob that bullied another child while adults stood by and did nothing, years later, as an adult, if we came upon a similar scene, we might find ourselves standing to the side, frozen into a Bystander stance.

The least problematic version of this dynamic is when we are triggered into the Savior role, but even then we might be delusional and project the past inappropriately onto the present and attempt to save people who do not need saving, who do not want our help, or, at the least, we move to help without appropriate sensitivity.

3. Traumatic reenactment and projective identification. Psychoanalysts have long argued that an unintegrated traumatic event compels us to revisit it, to return to the scene of the crime, to traumatically reenact. A girl abused throughout childhood finds herself romantically attracted to abusive men. A man repeatedly abandoned in childhood is left, without warning, by his wife, then again ten years later by his second wife, then again seven years later by his third wife, and twice more by his business partners.

Consider the mechanism through which this might occur: projective identification, which describes how one internalizes a *relationship*, not simply one's role in the relationship. We remember the mother-child *interaction*, and not simply our experience as a child. In non-traumatic transference, the memory of a relationship embeds itself through repetition, through our *procedural* memory. When we internalize a traumatic relationship, the memory embeds itself through significance, through our *event*, or *episodic*, memory. When we encounter a situation reminiscent of the earlier traumatic event, our memory of the original event becomes the lens through which we interpret our situation in the present moment. When we interact with others through this lens of memory, we not only transfer the original scene onto the present moment and transfer posttraumatic roles onto those around us, we also choose, are *drawn to recruit* others, and *entrain* others to enact roles from the original trauma. Our mind asks, "Are you the Savior? Or the Victim? Or the Bystander? Or the Perpetrator"? Like a stage director, we assign people to the roles of our original trauma, and begin to interact with them as if they were the actors in the scene. Finally, if what we remember is the set of interactions that together make up the traumatic event, *it does not matter which role we originally played*, whether we were the Savior, Victim, Bystander, or Perpetrator.

More viscerally, Marnie recreates her mother's prostitution and the night of the murder through her relationship with her horse. Twice we see Marnie, after seducing and stealing from an employer (through which act she plays her mother, the prostitute), going to a stable to ride her kept horse (through which she plays the sailor). The third time we see her ride Forio, she sees red, panics and rides the horse too hard; he breaks a leg and is writhing in pain. Hysterical, she knocks at the nearby farm door, borrows a pistol, and shoots her beloved (positioning herself as the Perpetrator).

4. The scene of the crime. The traumatic memory is a memory of the scene of the crime. We remember the role each person played in the traumatic episode.

Here is a hypothetical scene: Father (the Perpetrator) abuses his son (the Victim), while his younger daughter (a Bystander) watches, until the mother (the Savior) intervenes to stop it. All four people, comprising all four roles, hold the scene in their memories, including what they perceive to be the feelings and thoughts of those holding the other roles. The daughter holds in her memory what she imagines her brother, father and mother were feeling and thinking, and so on.

All four people will carry their subjective versions of the traumatic memory, including each of the four roles, and will have a complex of posttraumatic symptoms. Reenactment through projective identification is only one possible posttraumatic symptom shared by all four roles. Other symptoms can be shared to varying degrees by all as well: anxiety, intrusive imagery, avoidance, dissociation and traumatic transference.

5. Healing requires accepting the reality of, and integrating, all four posttraumatic roles. What does this mean for therapy? If the interpretation we suggest in this essay is accurate, to relieve our symptoms it will be necessary to integrate the memory of all four roles, in turn, as if we were each of those people. The Bystander must integrate the experience of the Victim. The Perpetrator must integrate the experience of the Savior. And, yes, the Victim must integrate the (previously imagined) experience of the abuser. Integration does not mean forgiveness or

compassion. It means seeing and consciously knowing a disowned part of you own mind, one that exerts control over us until we have absorbed and digested it.

Below, we will imagine ourselves as therapist, and that Marnie has approached us as a client, and will discuss how we would work with her. First, we must address the difference between the real-world healing process through which Rutland guided Marnie, and the artificial therapeutic container in which we as psychotherapists do our healing work.

The Therapeutic Container: Managing Power, Sex and Intimacy

Sean Connery's character, Mark Rutland, guides Marnie's therapeutic process. Just as we lead our clients into their own darkness and help them to integrate their pasts, so Rutland leads Marnie. If we practice deep transferential therapy, we must love and commit to our clients, as Rutland commits to and loves Marnie. Transferentially based therapeutic relationships are asymmetric. In session, we have more power than our clients; in many ways, they are our children. Rutland (who is referred to by his last name) has more power than Marnie (who is called by her first name). When she is triggered into a traumatic state, he cares for her as he would a scared, wounded child. Finally, Rutland is willing to play the Perpetrator (he blackmails her into marrying him and repeatedly forces her to face her fears), the Bystander (he stands to the side and allows her to betray him and herself by attempting to rob his company), the Victim (it is his company that is robbed, and his reputation that is damaged by his adoption of her) and the Savior (he pays her debts, rescues her from the police and from her own self-destructive behavior). As therapists working with traumatic transference, we must hold a strong, loving container, in which the client will see and accuse us of being their Perpetrator or Bystander, of being a Victim like them, or of being their Savior. The transferences will come and go while we maintain our engaged, loving stance with them. Rutland succeeds in healing a profoundly traumatized woman under his care. We would be fortunate to be as successful in therapy with our clients.

Yet, there are differences. Rutland commits himself fully to Marnie. As therapists, we work with many clients. We would only be able to work with one client if we were to commit as fully as Rutland does. As therapists, we must find ways to effect or support healing in our clients within the structure of regular, short meetings. However heartfelt our commitment is, our efforts are limited by the therapeutic contract.

Second, Rutland confuses sexual and romantic love between two adults with the guiding and caretaking love of a parent for his child. Because Mark Rutland and Marnie Edgard are both adults, his confusion is problematic but not damaging. In assuming responsibility for her mental health and manipulating her toward healing, he claims an adult position (thus he is identified as Mr. Rutland) and patronizes her (while she is identified as child Marnie). Their contract was established (however forced by Rutland) as a sexual one between two adults. His infantilization of her begins later and distorts but does not violate their contract. In contrast, our contract with our clients begins with and is properly based on a parental-like asymmetry of power. For us as therapists, to enter into a sexual relationship with our clients is likely to be experienced as an act of incest, an act through which we betray our responsibility to care for our clients because of our own immaturity and lack of impulse control. The damage caused by a single such betrayal will outweigh any number of hours of helpful therapy.

An Example of the Therapeutic Process with a Marnie as Client

In this example, we present a therapeutic process we and our students have employed, cautiously and with much anecdotal success. The techniques some of you might recognize

from the psychoanalytic and group therapy literature applied to traumatic transference in a one-on-one setting. We do not recommend that readers adopt these approaches unless they feel themselves competent—and have been assessed as such by experts—in working with trauma, transference and countertransference, and are receiving supervision. A common observation by psychoanalysts for the past century, which our experiences as clients and therapists, students and trainers, have confirmed, is that working directly with transference without adequate technical skill, self-awareness, mindfulness and humility can be retraumatizing to all involved. The protocol is stated clearly below, perhaps giving the impression that the authors assume omniscience or omnipotent authority. Rather, the intent is to clarify the therapeutic strategy and the intention of the therapist in the moment, and to explicitly frame each transferential intervention, in order that both therapist and client can more easily differentiate between present and past in the client (transference), and therapist in him/herself (countertransference).

In our protocol, we work with traumatic transference through a sequence of four steps. First we support a client in integrating the Savior role, then the Victim, then Bystander and, finally, the Perpetrator role.

The integration process requires the client empathize with each role, noticing the physical sensations, impulses, emotions, images, and thoughts that arise. To empathize does not mean to *sympathize*, or to excuse or forgive. Rather, to empathize is to put oneself in the place of others, to imagine their histories, thoughts, and feelings. As human beings, we instinctually empathize, however skillfully or poorly. Instinctually, we empathized with the others at the scene of the trauma. Our empathetic impressions from the scene of the crime are stored within us. To integrate and heal from the experience requires, in part, that we recall our empathetic impressions from the moments of the trauma.

As people who resemble Marnie come to us as clients, we will use her as an example. If she were a client, she would likely come to us unclear about why and how she acts out; confused about how to interact with other people and avoiding intimacy; suffering severe panic attacks; socially isolated and unable to feel her own emotions; and compelled to enact her strange kleptomaniaical ritual (which she does not realize reenacts the original traumatic scene of her childhood). Here are the four steps we could lead Marnie, or any client, through to integrate her early traumatic memories and relieve her of her negative symptoms.

Step one: Integrate the Savior. Ask your client the question, "If you faced that situation again, how could you make sure the outcome would not be terrible?" He should have an answer before you continue. Then invite him to reimagine the situation, now with a solution. Have your client practice this reimagination until he feels confident his solution, if a like situation were to arise, would prevent a recurrence of the trauma. If your client cannot imagine a solution, tell him that you can; then offer solutions, one after another. In doing so, you, as therapist, are holding the Savior role. Be confident and hold out hope until your client embraces a solution. Once your client has a solution, let go of the Savior role and let your client take it on. If you continue to embrace the role of Savior, it will keep your client weak. Let him be the Savior, not you.

With Marnie, we ask, "If you were to face that situation again, with the sailor and your mother, how could you make sure the outcome would be better"? Her answer is simple, though perhaps difficult for Marnie to grasp; Marnie is an adult now and will never be a young child again, completely dependent on the adults around her. The situation *cannot* recur. We would invite Marnie to reimagine the situation, but with her now as an adult. This

would be an easy task for Marnie because she now lives the solution every day. She is an adult and supports her mother financially so there is no risk of her mother turning to prostitution again and thus endangering herself or any children dependent on her. We would invite Marnie to dwell on this realization while being mindful of her physical sensations, impulses, emotions and thoughts until her body relaxes and her thoughts quiet. She might be well aware of how she now plays the Savior — or this way of thinking about her life might confuse or upset her. If she is not able to accept that she is doing well for herself and protecting her mother from a traumatic reenactment, we will hold that awareness and stubbornly persist in recognizing her strength and value until she owns these qualities herself. We persist with her until she fully accepts how she plays the Savior role in her life. Once she does so, we will stop embodying and acting from the Savior role so as to allow her to hold the role more fully.

Next, we invite her to embrace how she played the Savior at the original scene of the crime. She thought the sailor was going to hurt her and her mother, and she protected them both by killing him. She is alive and her mother is alive. Her actions were successful. This is not to say that her actions in killing the sailor were morally right or conducive to an ideal solution. That complex moral consideration will come later. Right now, what is important is for her to embrace the truth that the solution worked. Neither she nor her mother was beaten, raped or killed by that sailor, any sailor, or any other male since. Again, we as therapists will embrace the success of the killing, however brutal, until she does as well. Once she does so, we will no longer need to champion this painful truth.

Finally, we invite her to empathize with anyone else present at the original scene of the crime that played the Savior role. Her mother played the Savior. Through her work as a prostitute, she kept herself and her daughter sheltered and fed. Also, afterward, she testified in court that she had killed the sailor, not her daughter. She protected Marnie from the police and the court system (as Mark Rutland was to do for Marnie two decades later). As therapist, we will empathize with Marnie's mother until Marnie herself can empathize with this aspect of her mother.

Marnie might now understand better why and how she acts out. She might be a little less confused about how to interact with other people and is perhaps becoming less avoidant of them. However, she still probably has severe panic attacks, is socially isolated and unable to feel her own emotions and, despite her dawning self-awareness, is still compelled to reenact the original scene of the crime.

Step two: Integrate the Victim. Ask your client what damage the original trauma and its aftermath have done to him: "How might your life have been different if the original trauma had never occurred?" Invite him to reimagine his life, year by year, and his significant relationships, and how those might have been had the trauma never occurred. As with the Savior role, if your client cannot fully feel the role of Victim, demonstrate the role for him. As therapist, feel and express the grief for a life not lived because of the traumatic events. In doing so, you are holding the Victim role for your client. Keep holding the role until your client begins to feel his own grief. Once he can, let go of your grief. Allow space for him to fully feel his.

With Marnie, we ask, "How might your life have been different if the original trauma and its aftermath had never happened?" She might first answer that she wouldn't be hunted by the police or trapped in a marriage with Rutland. After more reflection, she might wish for a simpler life, without theft and the need to repeatedly change her identity. She might imagine that her mother, instead of being cold and critical, would act lovingly toward her. She might

imagine that she could have had friends during her childhood as well as now, and that she might have a close, trusted relationship with a partner. She might feel that she has lost the life being lived by the little girl Marnie envies, who lives next door to her mother and to whom Bernice is kind— the little girl who smiles and is open, trusting and full of life. If Marnie cannot feel what she has lost, we would feel, express, and so demonstrate this grief until she can feel it herself. We persist with her until she accepts what she has lost. Once she begins to feel her loss, we can drop the Victim role, to allow her to hold it more fully.

Next, we invite her to embrace how she played a Victim at the original scene of the crime. As a little girl, Marnie was afraid of the sailor. When the sailor fell on her mother and injured her, he indirectly hurt Marnie as well because, as a young child, she was utterly dependent on her mother. Marnie was doubtless overwhelmed by the danger and violence of the scene. More directly, Marnie experienced the Victim role after the murder, when she lost her mother's affection. Her mother became oppressive, cold and controlled, and Marnie, in addition to becoming compelled to protect her mother, became obsessed with the endeavor to regain her mother's love. As therapists, it is our role to feel and express this pain of a life unlived until Marnie can feel the pain for herself.

Finally, we invite Marnie to empathize with anyone else present at the original scene of the crime who was a Victim. Her mother was a Victim, simply through her profession as a prostitute for drunken sailors. When the sailor threw her down, she was badly hurt and needed a cane for support for the rest of her life. After her mother took responsibility for Marnie's crime, Bernice was surely condemned socially, and this would have contributed to the isolated life we see her live during the film. The sailor was a Victim, too. We do not know his intention toward the six-year-old Marnie, or toward Bernice when he pushed her away and then fell on her. Nevertheless, whether what occurred was no more than a rough misunderstanding or an attempt at molesting or harming Bernice, the sailor was bludgeoned to death. Though he was perceived as a threat and Perpetrator by Bernice and Marnie, the only person killed was the sailor. Thus he embodied the archetypical experience of Victim. As therapists, we will empathize with Marnie's mother, as well as with the sailor, until Marnie herself can.

After integrating the Victim, Marnie now might understand herself better and interact better with others. Her panic attacks might now be milder and less easily triggered, but she might well still be isolated socially, unable to feel her own emotions (except grief) without help, continually still compelled to reenact the original scene of the crime.

Step three: Integrate the Bystander. Ask your client, "Who, by getting involved, might have helped this situation, yet did not?" Invite your client to reimagine his life, and how it might have been different had someone stepped in to help him. If he cannot, consider and name those who carried the responsibility for the traumatic events by virtue of not helping. Name them and note their absence until the client feels their absence, and empathizes with them. This role of Bystander can be particularly difficult for the therapist to assume, since we as therapists are actively engaged with the memories of our clients, but are Bystanders to the actual events of the hundreds of traumatic stories we hear. We must accept our own helplessness, and be willing to hold the position of those who did not help at the time of the original trauma.

With Marnie, we ask, "Who, by getting involved, might have helped this situation, yet did not?" Invite her to reimagine her life, year by year, her significant relationships, and how her life might have been different had someone stepped in to help her. If she cannot do this,

make suggestions. For example, where was her father? He bears indirect responsibility for her mother's profession and thus the dangers of that night, and for her mother's harsh treatment of Marnie thereafter. Persist with the idea of her father's neglect and its consequences until she begins to feel his abandonment of her. Once she begins to feel the abandonment, she may turn on you, the therapist, and blame you for your passivity, detachment and incompetence. It is your task to allow her projections on you to arise, come to full strength, and fade. Eventually Marnie will feel her projected mixture of the detachment, guilt and relief of her father, who was not at the original traumatic scene. She might withdraw from her relationship with you. Once she thus assumes the Bystander role, it is time for you as therapist to drop the role and stay engaged with her while she detaches from you, thereby allowing her to hold the Bystander role more fully.

Next, we invite Marnie to embrace how she played a Bystander at the original scene of the crime, when she stood by helplessly as the sailor crippled her mother. We will invite and express feelings of helplessness until Marnie is able to.

Finally, we invite Marnie to empathize with anyone else present at the original scene of the crime who was a Bystander. Her mother was. Her mother saw her little daughter beat the sailor to death. The sailor was a Bystander, when he entered the apartment and saw a little girl sleeping in the bed where he would lie with her mother. Marnie's father was present at the scene by his absence — meaning that in the milieu of the film, the United States in 1964, it would have been normal for a child to have had a father, and expected that the father would protect his wife and child. If most of Marnie's neighborhood or school peers had fathers, she would have felt the absence of hers. If her father had remained in Marnie's life, it is probable that none of this would have happened. As therapist, we empathize with Marnie, her mother, the sailor and Marnie's father until Marnie can herself. When she can empathize with the various Bystanders, we will drop the role of the Bystander, thus enabling her to integrate it fully.

Marnie might continue to understand herself better and, in her life out of therapy, she might interact better with others. Her panic attacks might be gone. She might have begun to form social relationships and to feel more emotions. Yet possibly still she may continue to be compelled to reenact the original scene of the crime.

Step four: Integrate the Perpetrator. Ask your client, "Who directly contributed to this trauma"? Once again, if the client can't say, make suggestions. As therapist, consider and name those who perpetrated terrible actions as part of the traumatic event. Name those actions, gently, until the client feels them and is able to empathize with each person who was a Perpetrator. Once the client recognizes and can empathize with the Perpetrator, let go of the role. Allow space for your client to feel how he is a Perpetrator.

With Marnie, we ask, "Who directly contributed to the trauma?" If she cannot answer, make suggestions. The sailor contributed because he pushed, fell on and crippled her mother. Her mother contributed because she struck the sailor with the fire iron. Marnie contributed because she picked up the iron and bludgeoned him to death.

Next, invite Marnie to embrace how she played the Perpetrator at the original scene of the crime, as she struck the sailor's head with the fire iron. We help Marnie to feel her single-minded aggression until she is able to do so without our help.

Finally, we invite Marnie to empathize with anyone else present at the original scene of the crime who was a Perpetrator. We persist in the idea that she can empathize with each act of perpetration because she *had* empathized with those who took those actions, back during the moments of the original trauma. Once she begins to fill the role of Perpetrator, she may

turn on you and blame you for hurting her, by making her feel these terrible feelings or for some other reason, real or imagined. It is your task, as therapist, to allow her projections on you to rise and fall. Eventually she will feel the isolation and aggression of the Perpetrator. Once she has thus assumed the role, it is time for you, as therapist, to drop the role and stay engaged with her while she cuts off from you and (verbally) attacks you. Allow her to hold and integrate the Perpetrator role fully.

Now, at the completion of therapy, Marnie presumably understands herself better. Her social relationships hopefully continue to improve and deepen. She might continue to feel and explore her emotions. Her compulsion to reenact the original trauma might be gone.

Training and Countertransference

Since traumatic transference can lead to destructive relational dynamics in therapy and a client's personal life, it is important to work with it directly. You can master the ability to work with traumatic transference with less broad training than would be necessary for full psychoanalytic mastery. Instead of dozens of transference dynamics, traumatic transference is limited to the four transferences described in this essay — Savior, Victim, Bystander, Perpetrator — though those four transferences are particularly strong.

Working with traumatic transference requires working with each role in a different way. Psychotherapy with a client who is unable to assume the Savior role, or who is overly attached to the Savior role, is managed differently from psychotherapy with clients for whom the presenting role is Victim, Bystander or Perpetrator. Addressing each role requires different technical skills.[4]

More importantly, addressing each role requires the therapist to be able to embrace or let go of each of the four roles when and in a manner beneficial to the client. This is not an easy skill to master, and requires the therapist to learn about her own traumatic and characterological countertransferences. The therapist needs to learn the limits of her own ability to move into or out of the four roles. She needs to learn her attachment or repulsion to each of the four roles. She needs to learn what circumstances trigger her toward or away from each role. Then, with this self-awareness, she needs to do the difficult, time-consuming inner work necessary to embrace and let go of each role. This is a process, both deeply unsettling and rewarding, that requires years of focused effort. Once she has done much of her own work with transference, she will be able to meet, mirror and guide her clients toward the integration of the traumatic memories that shape and drive their lives and relationships.

Implications

As therapists, we bring our own counter-transferential tendencies, our own history of relationships and our own traumas to the therapeutic relationship. The stronger our counter-transferences are, the less fluid we are, and the less capable we are of working skillfully with our clients. Therapists commonly find some roles attractive and others repulsive. For example, therapists who are uncomfortable with negative transference may have a difficult time allowing clients to view them as unhelpful, incompetent, or antagonistic, yet allowing and not resisting these negative transferences may be necessary for the client's relational healing to occur. If the therapist insists on persisting only in

[4] Which are outside of the scope of this essay.

the (Savior) role of the competent, loving, attuned parent, the negative transference roles which clients carry with them but have not yet integrated into their psyches migrate to other relationships in their lives. In other words, in this case, the therapist assumes the Savior role in the client's psyche, and the client's intimate partners are left holding only the Bystander and Perpetrator roles, which stress and can ruin those relationships. The significance of this dynamic cannot be overstated, for our clients' lives and our own, for our private practices, and for the field as a whole.

In short, traumatic transference is both real and powerful, and can be destructive. Like Marnie and most of our clients, some of us have found ourselves in terrible relational dynamics, which we have created, chosen or acquiesced to. Sometimes our traumatic reenactments are simply stressful, but other times they become new traumas in themselves. Recall the horror Marnie expresses when she must kill her beloved Forio to end his pain. Consider the pain and regret many of us feel when we find ourselves in our own dilemmas, in which any choice we make will have bad, or even terrible, consequences.

Finally, working with traumatic transference can be unpleasant and confusing. It is important for us to keep a sense of perspective, so as not to lose ourselves in the client's drama, nor to fully separate ourselves from the client. Gentle humor can help to leaven the mood and strengthen our mindfulness. How does our guide, Mr. Hitchcock, manage this balance, while he is immersed in his filmmaking and his characters' lives and working through his own anxiety? One way is his personal appearance in his later films. Like an extra, he passes through the background of the scene of crime. In this way he winks at us. He invites us to simultaneously enter and stand apart from the film as we watch it. Did you notice him in *Marnie?*[5]

BIOGRAPHIES

Eric Wolterstorff, received his PhD in sociology, with a specialization in how groups respond to threats, from the Union Institute and University (2003). He studied for years under traumatologist Peter Levine, body-based psychotherapist Pat Ogden, rolfers Peter Melchior and Emmett Hutchins, and group conflict facilitators Arnie Mindell and Max Schupbach. The heart of his work is to understand how large groups and societies can address their group-response-to-threat dynamics, to overcome collective past traumas (such as wars, natural disasters, environmental destruction) and to proactively respond to national threats.
Email: ewolterstorff@gmail.com Website: www.somatic-memory.com

Herbert Grassmann PhD, is the director of the European Association of Somatic Traumatherapy (EAST), head of the Institute for Structural Core Therapy (SKT), and founder of SKT® Strukturelle Körpertherapie and TraumaSomatics®. He is also a trainer, clinical therapist and supervisor, in addition to the chair of the EABP Science and Research Committee. He conducts trainings in several business organizations and leads presentations and workshops throughout the world. In the late 80s and early 90s he trained in Structural Integration with Pat Ogden (Certified Hakomi Practitioner) and in trauma therapy with Peter Levine. He is the author of several articles and the book, *Zwei im Einklang*, Kreutz-Verlag, 2004.
Email: herbertgrassmann@nefkom.net Website: www.somatic-memory.com.

[5] Here's a hint: He made his move in the first five minutes of the film.

REFERENCES

Bandura, A. (1965). "Influence of model's reinforcement contingencies on the acquisition of imitative responses." *Journal of Personality and Social Psychology* 1: 589-595.

Bandura, A. (1966). "Vicarious processes: A case of no-trial learning." Pp. 1-55 in *Advances in experimental social psychology*, edited by L. Berkowitz. New York: Academic Press.

Bandura, A., & Rosenthal, T. L. (1966). "Vicarious classical conditioning as a function of arousal level." *Journal of Pers. Soc.* Psychology 3`.

Bowen, M. A. (1990). *Family Therapy in Clinical Practice.* Jason Aronson Publishing.

Easterbrook, J. A. (1959). "The Effect of Emotion on Cue Utilization and the Organization of Behavior." *Psychological Review* 66: 183-201.

Grigsby, J., and Stevens, D. (2000). *Neurodynamics of Personality.* New York: Guilford Publications.

Levine, P. (1976). *Accumulated Stress, Reserve Capacity, and Disease.* Lyons, Colorado. Ergos Institute Press.

Schore, A. (1994). *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development.* Hillsdale, NJ and Hove, UK: Lawrence Erlbaum Associates, Publishers.

Schore, A. (1997). "A century after Freud's project: is a rapprochement between psychoanalysis and neurobiology at hand?" *Journal of the American Psychoanalytic Association* 45: 807-840.

Schore, A. (2001). "An Interview with Allan Schore." Roz Carroll. Retrieved from: http://www.thinkbody.co.uk/papers/interview-with-allan-s.htm

Schore, A. (2002). "Clinical implications of a psychoneurobiological model of projective identification." Pp. 1-65 in Primitive mental states: *Psychobiological and psychoanalytic perspectives on early trauma and personality development,* edited by Shelley Alhanati. London: Karnac Books.

Schore, Allan. (2003). *Affect Regulation and the Repair of the Self.* New York: Guildford Press.

Schwartz, Z., Dohrenwend, B.P., & Levav, I. (1994). "Nongenetic familial transmission of psychiatric disorders? Evidence from children of holocaust survivors." *Journal of Health and Social Behavior* 35: 385-402.

Seligman, S. (1999a). "Infant-parent interactions, phantasies, and an 'internal two-person psychology:' Reply to commentaries." *Psychoanalytic Dialogues* 9: 235-243.

Seligman, S. (1999b). "Integrating Kleinian theory and intersubjective infant research observing projective identification." "*Psychoanalytic Dialogues* 9: 129-159.

Shapiro, R. B. (1985). "Separation-individuation and the compulsion to repeat." *Contemporary Psychoanalysis* 21: 297-308.

Silverman, R. C., & Lieberman, A. F. (1999a). "Negative maternal attributions, projective identification, and the intergenerational transmission of violent relational patterns." *Psychoanalytic Dialogues* 9: 161-186.

Silverman, R. C. & Lieberman, A. F. (1999b). "Reply to commentaries." *Psychoanalytic Dialogues* 9: 229-235.

Terr, L. (1981). "Forbidden Games: Post-traumatic Child's Play." *Journal of the American Academy of Child and Adolescent Psychology* 20: 741-760.

Terr, L. (1994). *Unchained Memories.* New York: BasicBooks.

van der Hart, O., van Dijke, A., van Son, M., & Steele, K. (2000). "Somatoform dissociation in traumatized World War I combat soldiers: a neglected clinical heritage." *Journal of Trauma and Dissociation* 1: 33-66.

van der Kolk, B. (1989). "The compulsion to repeat trauma: revictimization, attachment and masochism." *Psychiatric Clinics of North America* 12: 389-411.

van der Kolk, B. (1994). "Foreword," in *Countertransference in the Treatment of PTSD*, edited by Jacob D. Lindy and John P. Wilson. New York and London: The Guildford Press.

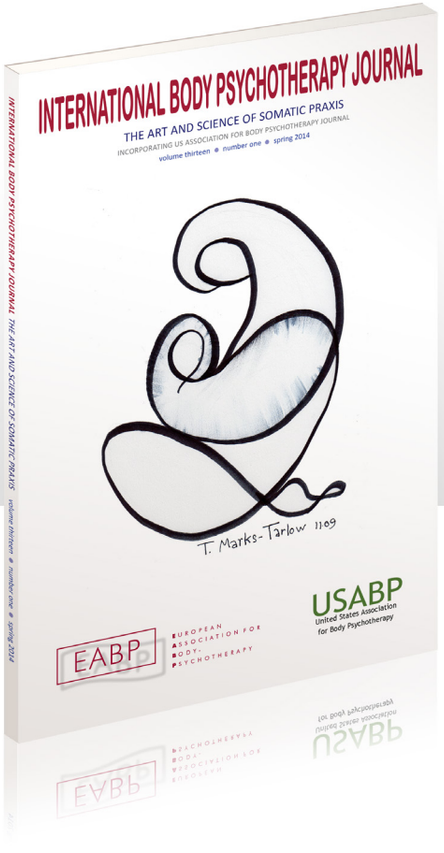
van der Kolk, B. & Fisler, R. (1995). "Dissociation and the Fragmentary Nature of Traumatic Memories: Overview and Exploratory Study." *Journal of Traumatic Stress* 8: 505-525.

van der Kolk, B., McFarlane, A. C., & Weisaeth, L. (1996). *Traumatic Stress: the Effects Overwhelming Experience on Mind, Body and Society.* New York: The Guilford Press.

Wolterstorff, E. (2003). Dissertation: *A Speculative Model of How Groups Respond to Threats.* The Union Institute and University. Cincinnati, Ohio.

Zender, J. F. (1991). "Projective identification in group psychotherapy." *Group Analysis* 24: 117-129.

Zosky, D. M. (2001). "The role of *projective identification* with domestically violent males." *Dissertation Abstracts International Section A: Humanities and Social Sciences* 62.



INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

Print subscriptions

Printed single issue: Members €17.50, Non-members €20
Yearly subscription: Members €30, Non-members €35
Two-year subscription: Members €55.00, Non-members €60.

Payment through bank transfer, American Express or PayPal.

Online issues are available free of charge
www.ibpj.org

INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL THE ART AND SCIENCE OF SOMATIC PRAXIS

Letters to the Editor
The editors are eager to receive letters, particularly communications commenting on and debating works already published in the journal, but also suggestions and requests for additional features. A selection of those received will be published in the next volume of the Journal.

Advertising Information
The IBPJ Journal accepts advertisements for books, conferences, training programs, etc. of possible interest to our members. Please contact Jill van der Aa jill.vanderaa@eabp.org for more information.

Criteria for Acceptance
The Journal's mission is to support, promote and stimulate the exchange of ideas, scholarship and research within the field of body psychotherapy as well as to encourage an interdisciplinary exchange with related fields of clinical theory and practice.

First consideration will be given to articles of original theory, qualitative and quantitative research, experiential data, case studies, as well as comparative and secondary analyses and literature reviews. Submission of an article to the *International Body Psychotherapy Journal* represents certification on the part of the author that it has not been published or submitted for publication elsewhere.

Our Editor and reviewers will read each article with the following questions in mind:
- How does material in this manuscript inform the field and add to the body of knowledge?
- If it is a description of what we already know, is there some unique nugget or gem the reader can store away or hold onto?
- If it is a case study, is there a balance among the elements, i.e., background information, description of prescribed interventions and how they work, outcomes that add to our body of knowledge?
- If this is a reflective piece, does it tie together elements in the field to create a new perspective?
- Given that the field does not easily lend itself to controlled studies and statistics, if the manuscript submitted presents such, is the analysis forced or is it something other than it purports to be?

Authors' Guidelines
For full submission details please consult the EABP website:

Submission: Articles must be submitted by email.

Formatting:
Please consult the latest edition of the Publication Manual of the American Psychological Association.
Manuscript should be single-spaced in 10pt. type, with a one-inch (25 mm) margin on all four sides. Please include page numbers. Paragraph indent .5cm. The manuscript must be free of other formatting.
Order of information: Title, full authorship, abstract (±100-350 words), key words (3-5), text, references, biography (100 words). The biography should include the author's degrees, institutional affiliations, training, e-mail address, acknowledgment of research support, etc.

References: References within the text should include author's surname, publication date and page number. Full attribution should be included in the references at the end. We generally follow American Psychological Association standards for citation. (Citation Simplifier.) Copyright permission must accompany any diagrams or charts copied or altered from published sources.

This citation simplifier website takes all the fuss out of writing the bibliography! If you need to use a different citation style for any other reason, they can be found on the left-hand side of the page. Click on what is required for your needs. We request APA-formatting, so on this page, click on the type of resource you need to cite (be it book, blog, article, etc). Fill in all the information it demands of you (click the + button to add an author if your source has more than one), click "Make Citation," and there you'll have it, an appropriately-formatted bibliographic citation that can be copy-and-pasted directly onto your work.

Of course, you may wish to consult a more comprehensive resource about APA style guidelines, how to do in-line citations. As for how to find all the information that you need to make a citation, referring to the primary source you used will be best and most exhaustive. If you no longer have access to that, a quick Google search with the information that you do happen to have (book/article title along with author's name) will often provide the rest in the first few hits. Start by clicking on the first Google result, and by eye, search for the information that the citation machine website asks for specifically. Browse the next couple of links on Google if need be. If the information needed (e.g page numbers) can't be found in the first few hits, it is unlikely that it will be online at all.

Language: Authors are responsible for preparing clearly written English language manuscripts free of errors in spelling, grammar or punctuation and also for correct translations. Grammarly is an automated proofreader and grammar coach.
If the article is originally written in a language other than English please submit it and we will publish it on our websites.

Peer Reviewing: All articles are peer reviewed by three reviewers. During this process suggestions for review or alteration will be sent to the author. Final decisions are made at the joint discretion of the author and the editor. Before the Journal goes to the printer authors will receive a copy to check for typographical errors and must return corrections by email within the time limit specified.

Confidentiality: Please note, To ensure the confidentiality of any individuals who may be mentioned in case material, please make sure that names and identifying information have been disguised to make them anonymous, i.e., fictional and not identifiable.

Authors' copyright: It is a condition of publication that authors license copyright in their articles, including abstracts, in the IBPJ. This enables us to ensure full copyright protection and to disseminate the article, and the Journal, to the widest possible readership in print and electronic formats, as appropriate. Authors may, of course, use the material elsewhere after publication, providing that prior permission is obtained from the IBPJ. Authors are themselves responsible for obtaining permission to reproduce copyright material from other sources.
Submission of a manuscript to the Journal will be taken to imply that it presents original, unpublished work not under consideration for publication elsewhere. By submitting a manuscript, the authors agree that the exclusive right to reproduce and distribute the article has been given to the Publishers, including reprints, photographic reproductions of a similar nature and translations.

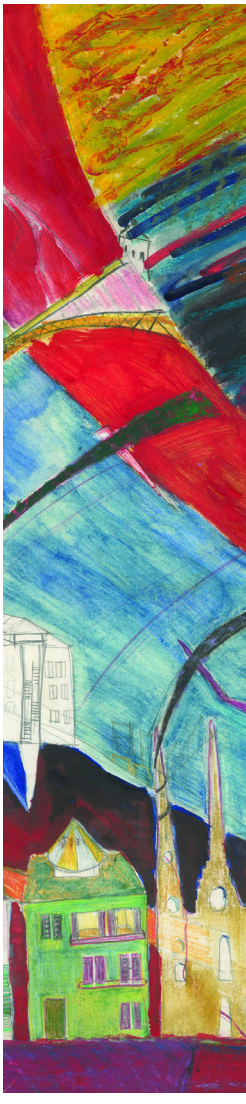
INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

volume thirteen • number two • fall 2014

TABLE OF CONTENTS



www.ibpj.org

EABP
EUROPEAN ASSOCIATION FOR BODY-PSYCHOTHERAPY

USABP
United States Association for Body Psychotherapy

Journal (ISSN 2169-4745)