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ARTICLE

From Passion to Action: A Synopsis of the Theory and Practice of Enactive Trauma Therapy

ELLERT R. S. NIJENHUIS, Ph.D.¹ ²

Enactive trauma therapy is influenced by the philosophy of enactivism, among other sources of inspiration. Enactivism holds that, like anyone else, traumatized individuals (1) are embodied and embedded in their environment; (2) are goal-oriented human organism-environment systems that primarily long and strive to preserve their existence; (3) are primordial affective systems oriented toward making sense of things; (4) bring forth, i.e., enact a mental and phenomenal self, world, and self-as-a-part-of-this-world, and (5) primarily gain knowledge on the basis of their goal-oriented sensorimotor and affect-laden actions. In this light, trauma is an injury to a whole human organism-environment system. Its core is a lack of integration of various dynamic modes of longing and striving: those that concern longings to live daily life and to avoid perceived threat (notably including traumatic memories) and those that involve longings to defend the integrity of the body. In dissociative disorders, these modes take the form of two or more conscious and self-conscious dissociative subsystems that enact their own mental and phenomenal self, world, and self-as-a-part-of-this-world. Enactive trauma therapy is the endeavor to mend the integrative deficit. It is comprised of the patient and the therapist as two organism-environment systems that enact a common world and that long and strive to achieve common results. Together they spawn new actions and meaning. Their collaboration and communication resembles dancing: It takes pacing, attunement, timing, a sensitivity to balance, movement and rhythm,

¹ I kindly thank Dr. Andreas Laddis for his important editorial work.
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courage, as well as the ability and willingness to follow and lead. I propose and illustrate several principles for the progression from passions to actions. Individuals engage in passions and experience sorrow the more they are mostly acted on, that is, influenced by external causes. The more they are their own master, the more they act, and the more they act, the more they experience joy.

KEYWORDS enactive trauma therapy; enactivism; action psychology; dissociation; primordial goal-orientation; primordial affectivity

Desire is man’s very essence, insofar as it is conceived to be determined, from any given affection of it, to do something.

Baruch d’Espinoza, 1677, III, Definition of the Affects I

...what is always to be found in every animal consciousness, even the most imperfect and feeblest, in fact what is always its foundation, is the immediate awareness of a longing, and of its alternate satisfaction or non-satisfaction in very different degrees.

Arthur Schopenhauer, 1844, p. 204

Ideally, trauma therapy is grounded on defensible philosophical premises and a coherent, cohesive, and useful theory of human experience, thought, and behavior. Sound premises and a viable theory greatly empower therapists to comprehend the intricacies of trauma in general and of chronic interpersonal trauma in particular. Furthermore, these navigational instruments empower therapists to engage patients in intrinsic coaction and create a path of healing from the injury that trauma is.

As its name indicates, enactive trauma therapy is strongly inspired by enactivism, a combined philosophical, biological, and psychological perspective (Colombetti, 2014; De Jaegher & Di Paolo, 2007; Thompson, 2007; Varela, 1997; Varela, Thompson, & Rosch, 1991). Enactivism’s formulations comprise a synthesis of novel and age-old themes. For example, enactivism’s roots go back to shining ideas of several classic authors, like the philosopher Zhuang Zi (ca. 369–286 BC; Wu-Chi, 1990), the philosopher and psychologist Spinoza (1677), and the philosopher Schopenhauer (1819, 1844). More recent sources include the phenomenologists Husserl (1954) and Merleau-Ponty (1945) and the philosopher Wittgenstein (1953) (see Nijenhuis, 2015a,b, 2017). To illustrate the theoretical and clinical relevance of their ideas, the present paper includes some of Spinoza’s and Schopenhauer’s most pertinent insights.

Enactivism places affectivity, goal orientation, sense making, embodiment, and environmental embedment at the heart of organizing sensation, perception, emotion, thought, memory, imagination, and behavior. Its perspective is therefore to be distinguished from currently quite popular approaches that place cognition, computation, ‘information processing,’ or
behavior in the center. **Enactivism indeed introduces a different paradigm of organismic experience, knowledge, and behavior.**

Other sources of inspiration for enactive trauma therapy include, but are not limited to, Janet’s psychology of action and insights from structural dissociation theory (Van der Hart, Nijenhuis, & Steele, 2006), ecological psychology, and dynamic systems theory. Readers will find a full account of enactive therapy’s philosophical, theoretical, and empirical underpinnings in the trilogy *The Trinity of Trauma: Ignorance, Fragility, and Control* (Nijenhuis, 2015a,b, 2017).

In this article I offer several principles of enactivism (Nijenhuis, 2015a,b, 2017) as I apply each of them to trauma and enactive trauma therapy. A transcript of an episode from therapy serves to illustrate a sample of my practice.

### 1. ENACTIVISM AS A NAVIGATIONAL INSTRUMENT IN TRAUMA THERAPY

#### 1.1. Being and Becoming in Doing

The verb ‘to enact’ and the adjective ‘enactive’ express that what individuals experience and know is deeply influenced by how they act (Protevi, 2006). *Experiencing and knowing is being and becoming in continual doing.* A major component of doing involves the subject’s affectively charged sensorimotor actions.

**Implication for enactive trauma therapy 1:**

Enactive trauma therapists’ primary and deep interest is in the traumatized individuals’ and their own ongoing affectively charged, sensorimotor actions. They mind bodies and hearts alike. As is detailed below, they realize (i.e., know and heed the consequences of this knowing) that, like all organisms, patients and therapists are primarily longing and striving to fulfill their longings by engaging in world-oriented embodied action.

#### 1.2. Longing and Striving; Action and Passion

To be and to become is to *act*, mentally and behaviorally. Mental actions include feeling, perceiving, thinking, remembering, and imagining—say, imagining a future. Apart from mental actions, behavioral actions include goal-oriented bodily movements. A basic question is: *Why* do organisms act? For example, why do patients, including traumatized individuals and clinicians, think or move in one way or another?

Understanding the material brain processes cannot tell what causes organisms to act in the ways they do. Nor can it tell us *what it is like* to experience, think, or do this or that. Answering the why question and
the what-it-is-like-question takes an understanding and appreciation of the mind (Bitbol, 2008; Schopenhauer, 1844; Spinoza, 1677; Turner, 2017).

Like all organisms, persons inherently long and strive to preserve their existence, to increase their power to exist (Schopenhauer, 1844; Spinoza, 1677). They continually long and strive for what seems useful to them and to avoid or end what seems harmful to them; they also leave what is insignificant to them alone. They explore, procreate, and defend themselves; they play and they bond.

To fulfill those longings, individuals need power of action. Individuals engage in actions inasmuch as they act mostly on account of their own power. In that case, they are agents. When individuals fulfill their longings as a result of their actions, they gain power of action and experience joy.

When individuals are mostly acted upon by external forces, they engage in passions. When these forces harm them, they experience sorrow. Passions, then, are substitute actions, compositions of lesser complexity and power that take the place of more efficient, viable, and creative actions that lie beyond an individual’s current power of action (Janet, 1903, 1909, 1928; Spinoza, 1677; Van der Hart et al., 2006). They are meaningful, albeit confused, efforts to organize and sustain life.

Like all living things, traumatized individuals long and strive to increase their power to exist, or at least to prevent losses. Like everyone else, they seek joy in action and shun sorrow. However, traumatized individuals’ power of action does not suffice to overcome the horrors they once met, just as it did not suffice then. They still suffer from being acted upon by external causes whose power once overcame their own power to persist with their strivings. Traumatized individuals’ passions and sorrow pervade all trauma-related symptoms such as nightmares, involuntary reenactments of traumatizing events, hearing voices, and being intruded by trauma-related bodily sensations or by different parts of their personality.

**Implication for enactive trauma therapy 2:**

Enactive trauma therapists encounter and conceive of patients as individuals who long and strive to heighten their power of healing a major injury that life has inflicted. They conceive of patients as individuals who have historically desired and struggled to preserve their existence in the best ways their power of action afforded. They regard patients’ symptoms as goal-directed passions that substitute for actions currently out of their reach. Enactive trauma therapists’ basic therapeutic “internet address” (www) is “who does what and why?”

Enactive trauma therapists conceive of themselves as coaches rather than as healers. As coaches they long and strive to help their patients to create a path from passion to action, to jointly bring forth a way that lessens patients’ sorrow and heightens the joy of their strivings’ fulfillment. They
also long to increase their own power of therapeutic action. To that end, they strive to experience, know, and do what is useful to patients and to refrain from doing what is useless and harmful to them.

Enactive trauma therapists appreciate that any gain in power of action is useful, hence brings joy, and that lack or loss of power of action is harmful, hence entails sorrow. In this mindframe, they strive for actions that individuals can currently achieve, that are within their present power of action. Enactive trauma therapists realize that these principles apply to patients and therapists in equal measure.

1.3. Signification

Cognition follows longing or will. People think because they have needs and desires that they strive to fulfill (Spinoza, 1677). As Schopenhauer (1844, p. 198) put it, “the will always appears as the primary and fundamental thing, and throughout asserts its preeminence over the intellect”.

The world is not meaningful in and of itself. People must make meaning. They must signify (Weber, 2002) what is useful, harmful, and insignificant to them. They must also signify what is self, what is other (not self; objects, other selves), and how self and other are or can become related. Individuals thus require a point of view regarding themselves, their world, and the relationships of their self and world—affectively, cognitively, and behaviorally (Colombetti, 2014; Spinoza, 1677; Varela et al., 1991). Traumatized individuals as well as their therapists are such longing, hence goal-oriented and sense making systems with a point of view.

Implication for enactive trauma therapy 3:

Enactive trauma therapists understand that longing precedes and guides perception and cognition. In that spirit, they assess, pace, and compare their patients’ and their own ongoing longing-based, affectively charged signification. They recognize that patients’ nonverbal, verbal, and paralinguistic expressions have a particular meaning. Thus, enactive trauma therapists pay much attention to the particularity of patients’ expressions, words, and thoughts of themselves and the world. For example, when a patient says, "I feel low" they will not say, "You seem depressed." They refrain from reformulating the patient’s words—as if they know better how to capture the patient’s mood; instead, they repeat and emphasize, "You feel low." When the patient reacts, "Yes" the therapist paces the patient by simply affirming, "Yes"; or, if the therapist senses that the patient feels very low, "Yes, low, really low." Enactive trauma therapists long and strive to attune to their patients’ signification.
1.4. Contrary Longings and Strivings: Vacillation of Body and Mind

Because people’s signification pertains to their needs (unconscious longings) and desires (conscious longings), shifts in meaning ensue from shifts from one longing to another and conflicts between different needs and desires. Outright opposite longings are tied to categorical contrary strivings and meanings within one individual. In people,

the more manifold [their] needs become, and the more varied and specially determined the objects capable of satisfying them, consequently
the more tortuous and lengthy the paths for arriving at these, which
must now all be known and found (Schopenhauer, 1844, p. 205).

People must somehow integrate their multiple needs and desires, as well as the longing-dependent signification. Needs and desires can be more or less complimentary or contradictory. Even “one and the same object can be the cause of many and contrary affects” and meanings, implying “vacillation of mind” (Spinoza, 1677, p. 80).

I must note here that a) the term “object” may apply to things or to other subjects, and b) that vacillation of mind implies vacillation of body, and vice versa, the mind and the body being two attributes or properties of individuals (Spinoza, 1677; see below and Nijenhuis, 2015a,b, 2017).

**Implication for enactive trauma therapy 4:**

Enactive trauma therapists assess and monitor whether patients’ and their own longings and strivings on the patients’ behalf are synergistic or opposite. The patients’ longings will not cease if the therapist disregards and negates them.

**Implication for enactive trauma therapy 5:**

Enactive trauma therapists adhere to the metaphysical proposition that the body and the mind are two properties of nature as a single substance. In this light, they do not tell fearful traumatized individuals that they are scared because their amygdala fires, or, conversely, that their amygdala fires because they are fearful. They regard being scared and amygdalar activity as different properties that are to some degree correlated. In their view, being afraid and certain brain excitation are somehow correlated, but neither causes the other. They may say that both fear and brain excitation are activity in relation to a certain threat. Enactive trauma therapists understand that the patient’s need to avert the threat is what determines both. Per the attribute of mind, they tend to the person’s fear. Per the attribute of matter, they may link fear to particular patterns of brain and physiological activity. However, they realize that they can do this, only because they have experienced fear and know what the fearful patient’s concern currently is. They realize that materialistic neuroscience presupposes mentality, a fact that many neuroscientists seem to overlook or prefer to ignore.
1.5. Vacillation of Mind and Body in Trauma
When they encounter horrific danger, people clearly long and strive to defend their integrity. They are bound to startle, flee, freeze, fight, and/or play dead. People experience other longings and strivings as well, for example, to eat, sleep, explore, attach, attain social recognition, and otherwise influence their fate. While they shift among their different longings and strivings, their mind and body will vacillate. The more the vacillations pertain to contrary longings and strivings, the more profound the shifts will be.

Such vacillation is most forceful in the body and mind of a child who is neglected, maltreated, or abused by a caretaker, say, his or her mother or father. The child then will long and strive to attach to the parent while frantically defending against the parent’s harmful actions or passions. Integrating these conflicting strivings may be well beyond the child’s power of action. That powerlessness may last during maturation and manifest as alternating tendencies to approach and avoid that parent.

*Implication for enactive trauma therapy 6:*
Enactive trauma therapists assess and monitor their patients’ mind and body vacillations and identify the object of conflicting longings, strivings, and significations, a person or thing. If patients desire to reconcile and integrate their conflicting wants, enactive trauma therapists help them to accomplish that, free of the therapists’ own interests and judgments.

1.6. Modes of Longing and Striving and Nonlinear Dynamic Systems
Vacillation of mind and body derives from the fact that individuals concurrently generate various states or modes\(^3\) of being and becoming (Nijenhuis, 2015a,b, 2017; Putnam, 2016). The involved modes of longing and striving are patterns of self-organization. They consist of a particular composition or *synthesis* of sensations, perceptions, feelings, thoughts, and behaviors that serve a particular longing. The more contrary two modes of longing and striving are, the more abrupt and profound vacillations between them become, jumping from one mode to the other. In one word, the person’s course of longing, feeling, thought and motor action is *nonlinear*.

According to the theory of nonlinear dynamic systems, people’s modes of being and becoming are guided by ‘attractors’ (Putnam, 2016). The longing to fulfill one need “attracts” a person to persist despite other influences that might interfere (perturbations). Reenactment of traumatizing events

\(^3\)I prefer the term ‘mode’ of being or becoming, because it conveys more dynamism than the term ‘state’ of being.
is particularly resistant to perturbations, say, a therapist’s “grounding” the patient to the "here and now".

I propose that basic longings constitute core attractors of modes of being and becoming (Nijenhuis, 2017). People are guided and constrained by various such longings (e.g., to eat, sleep, explore, have sex, care for children, defend the integrity of the body). A particular mode, e.g., defense, may involve submodes, such as startle, flight, freeze, fright, and death feigning.

**Implication for enactive trauma therapy 7:**

Enactive trauma therapists understand that patients’ actions and passions are guided by longings. In this frame, they explore these longings and examine why some of their patients’ syntheses (i.e., clusters of sensations, perceptions, thoughts, movements) are woefully incomplete.

1.7. Contrary Modes of Longing and Striving in Trauma

Traumatized individuals have much difficulty integrating their competing modes of longing and striving. They recurrently alternate between opposite longings, strivings, and meanings. Conflicting longings and modes may also be activated in parallel, therefore, mental and behavioral contents of one may intrude into another.

**Implication for enactive trauma therapy 8:**

Enactive trauma therapists perpetually assess and monitor their patients’ shifting modes of longing and striving and, when applicable, their patients’ alternating dissociative subsystems of the personality (see #2). They monitor the modes typical of each dissociative part, and how they influence each other, for better or worse. The positive dissociative sensorimotor and cognitive-emotional symptoms (feeling the pain or hearing the voice of another dissociative part) manifest such intrusions. Therapists value all modes or dissociative parts for their meaning in equal measure and do not take sides. For example, they value controlling dissociative parts just as much as the fragile childlike dissociative parts.

1.8. Individual and World

Self and world are not pregiven. Instead, individuals bring forth, that is, enact a self and a world. They also enact how their self and world are related.\(^4\) Without an (en)acting (sensing, perceiving, feeling, knowing, moving), embodied and environmentally embedded individual there is no

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\(^4\) This self, world, and connections of this self and world include mental and physical properties. They also include phenomenal properties inasmuch as individuals are conscious
world with properties, no mind, no self indeed (Varela, 1997; Varela et al., 1991; Weber, 2002). Like every form of life, people constitute an organism-environment system (Järvillehto, 1998a,b, 1999, 2000a,b; Schopenhauer, 1819, 1844; Spinoza, 1677).

**Implication for enactive trauma therapy 9:**

Enactive trauma therapists understand that trauma is an injury to a person’s power to enact a particular self in relation to the world. They are also aware that in trauma the human organism-environment system may become divided in conscious dissociative subsystems or parts, and they are mindful of that division’s implications. They understand that each dissociative part enacts his or her own self. Consequently, trauma healing requires therapists to join patients in action that will integrate the strivings and worlds of dissociative parts.

**Implication for enactive trauma therapy 10:**

Enactive trauma therapists enact a perspective of the world that converges in some crucial regards with the patient’s, separately for each dissociative part, if applicable. If therapists and patients enact divergent worlds, they are not useful to each other. On the other hand, if therapists attune to their patients’ world without counterpoise in a perspective of coaching patients to healing, they risk coenacting their patients’ psychopathology.

Therapist-patient coenactment is a prerequisite for, and the vehicle of, change. Engaging in an ongoing dance of coordination, cooperation, and communication, patients and therapists can in principle create a shared world that affords change (Gibson, 1977, 1979). Coenaction empowers therapeutic dyads to accomplish a common result: enhancement of patients’ ability to engage in new and useful actions that are needed to overcome their trauma. It widens their affective, experiential, cognitive, behavioral scope. A desirable side effect of effective therapeutic coenaction is that it also increases, or at least affirms, therapists’ power of action.

**Implication for enactive trauma therapy 11:**

Enactive trauma therapists conceive of themselves as coaches, rather than individuals who have the power to heal their patients. As coaches, they can and do empathically propose, invite, and encourage patients to replace passions for actions.

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of themselves, their world, and their self-as-a-part-of-this-world. The term “phenomenal” stands for “known through the senses rather than through thought or intuition” (Merriam-Webster).
1.9. Enactment of Various Person Perspectives

Like any individual, patients and therapists enact various person perspectives. Knowing and differentiating these is clinically most relevant.

‘First-person perspective’ stands for enacting an ‘I,’ a longing, experiential, and embodied subject with one’s longings and point of view.

‘Quasi-second-person perspective’ involves the experience of observing and judging oneself as if another. The ‘I’ then relates to ‘me, myself, mine’ in terms of agency and ownership (e.g., “This is my hand, my movement, my point of view, my room, my idea, my theory,” and “I defend, express, like, or dislike myself”).

‘Second-person perspective’ entails the experience of enaction in an ‘I-You’ relationship. It involves the experience-based judgment that ‘I’ relate to ‘You.’

‘Third-person perspective’ involves the experience of knowing that there are one or more ‘things’ or ‘objects’ with particular properties of interest (e.g., long, heavy, hard, with psychological disorder). These objects include other individuals and social events as the object of one’s interest, say, to assess mental disorder, or to know the indicated therapeutic interventions.

**Implication for enactive trauma therapy 12:**

Enactive trauma therapists realize that they are feeling and sensemaking subjects with a point of view, but so are their patients. They appreciate that their other-person perspectives depend on their first-person perspective. Therefore, they realize they do not own truth, but can only modestly enact their truth.

Enactive trauma therapists realize that their third-person judgment cannot tell them what it is like to be the traumatized individual that seeks their help. They allow that only the patient as a first person can know that. However, they still find value in approximating the ‘I’ enacted by their patients and the patients’ ‘I-me, myself, mine’ judgments by engaging in empathic second-person perspective regarding their patients.

Given the importance of joining and approximating their traumatized patients’ first-person perspective, enactive trauma therapists strive to master verbal, nonverbal and paralinguistic attunement to their patients’ perspective. To attain that, therapists must continually experience, know their own world perspective, and differentiate it from the patients’.

That, in turn, takes ongoing high levels and wide fields of consciousness in order to integrate their own varying person perspectives. Enactive trauma therapists are aware of the complexity of this task and are willing to detect and correct their errors.
2. DISSOCIATION OF THE PERSONALITY IN TRAUMA

2.1. Decomposition and Recomposition of the Human Organism-Environment System in Trauma

Trauma involves insufficiently integrated and conflicting longings and strivings. When an individual experiences those longings and strivings in a single first-person perspective, we understand them all as that person’s *modes of longing and striving*. When an individual experiences each of these modes as an ‘I’ with its own first-person perspective, we understand them as *dissociative subsystems or parts of a wider human organism-environment system* (Nijenhuis, 2017; Nijenhuis & Van der Hart, 2011a,b).

Dissociative parts engage in a variety of actions and passions to preserve their existence (Nijenhuis, 2017). Given their limited power of action, each persistently reenacts a rather fixed set of modes of longing and striving that were probably the best the person could bring to a life that was recurrently traumatizing. However, these enactments and reenactments seldom serve the part’s and the whole individual’s best current interests.

As mentioned before, some prototypical dissociative parts primarily long and strive to live daily life. We metaphorically call them *apparently normal parts of the personality* (ANPs). ANPs tend to day-to-day needs and desires such as rest, sleep, eat, explore, play, relate to others, give and receive care, and reproduce. To that end, ANPs strive to evade traumatic memories and the emotional dissociative parts who reenact these memories. When ANPs’ mental avoidance falters, other dissociative parts can intrude on them. ANPs may suffer intrusions from traumatic memories and other mental and behavioral contents that other dissociative parts bring forth. For ANPs, involuntary and aversive intrusions constitute passions: The intrusions are external forces that override ANPs’ power to prevent them from happening. For example, ANPs may be flooded by unnerving voices or bodily feelings of other dissociative parts. Some ANPs interpret the intrusions as being possessed/influenced by strange forces. The intruding emotional dissociative parts may also engage in passions. For example, reenactments of traumatic memories are passions, not actions.

Other prototypical dissociative parts typically long and strive to master adverse/traumatizing events. We distinguish two kinds of them, *fragile emotional parts* of the personality (fragile EPs) and *controlling emotional parts* (controlling EPs). Emotional EPs tend to be fixated in one or more modes of the mammalian defense system (e.g., flight, freeze, fight, or feigning death) and/or in the attachment cry. Controlling EPs manifest the will for self-determination and social dominance. These dissociative parts tend to imitate perpetrators or their partners in crime in some regards.
Implication for enactive trauma therapy 13:

Enactive trauma therapists realize that dissociative parts enact their own first-person perspective, different from conflicting modes of longing and striving of a single overarching self, as in borderline personality disorder. They appreciate that failure to make that discrimination has important clinical consequences. Dissociation entails lack of integration, but not all lack of integration is an instance of dissociation.

Implication for enactive trauma therapy 14:

Enactive trauma therapists consider and engage the whole system of dissociative parts. While attending to one part’s mode or modes of longing and striving, they keep in mind the existence and interests of the rest. More than this, they continuously invite and encourage the various dissociative parts to recognize, acknowledge, experience, and integrate all existing longings and strivings.

2.2. Interpersonal Relationship Determines the Level and Field of Consciousness

Different types of interpersonal relationships employ and develop different levels and fields of consciousness (Järvilehto, 2000b). Chronic interpersonal traumatization involves totalitarian perpetrators (“dictators”) and neglected, maltreated and abused victims as objects (“slaves”) of the perpetrator’s malice and selfishness. Because totalitarian relationships only take and maintain a relatively low level and small field of consciousness, perpetrators’ as well as the victims’ level and field of consciousness remain low and narrow.

Collaboration and open interpersonal communication demand and thereby generate higher levels and wider fields of consciousness in individuals (Järvilehto, 2000b). Many chronically traumatized individuals have not known collaboration and open communication. They may have seldom experienced benevolent, affectionate interest from significant others and from a benign and mindful community. Because of that impoverishment of social experience, the power and breadth of their consciousness is small in at least some crucial regards.

For example (see Table 1), dissociative part A may not be aware of dissociative part B. Part A may experience intrusions from B such as hearing B’s voice, but having no second-person perspective for B, part A perceives and conceives B’s voice as a ‘thing’ (third-person perspective).
TABLE 1 Overview of Variations in the Relationship of Dissociative Part A with Dissociative Part B

<table>
<thead>
<tr>
<th>Part A's perspective in regard to part B</th>
<th>Dissociative part A's experience and knowledge</th>
<th>Part A's relationship to B</th>
</tr>
</thead>
<tbody>
<tr>
<td>A fully dissociates B.</td>
<td>A does not experience or know B.</td>
<td>Dissociative amnesia for B's actions and passions; dissociative anesthesia regarding B's longings and strivings</td>
</tr>
<tr>
<td>Third-person perspective: A experiences and judges B as a thing, not a subject with a mind and agency. 'I-object' relationship.</td>
<td>A partially or more completely knows and regards B as an object.</td>
<td>A is strongly depersonalized regarding B; A treats B as if B were a thing. For example, A merely hears B as a voice.</td>
</tr>
<tr>
<td>Distant second-person perspective: A experiences and phenomenally judges B at a distance, however, as another subject. 'I-You' relationship.</td>
<td>A experiences and knows B as a subject.</td>
<td>A and B are in some kind of contact, but A does not feel or understand B's longings and strivings much.</td>
</tr>
<tr>
<td>Empathic second-person perspective: A experiences and phenomenally judges B intimately. 'I-You' relationship.</td>
<td>A experiences and knows B as a subject, and appreciates B’s longings and strivings.</td>
<td>A and B are in some kind of contact, and A empathizes with B's longings and strivings.</td>
</tr>
<tr>
<td>Quasi-second-person perspective: A experiences and phenomenally judges B as part of oneself 'I-me, myself, mine' relationship.</td>
<td>A experiences and knows B as a part of himself/herself.</td>
<td>A and B are not dissociative parts but more or less integrated modes of longing and striving. The involved modes may or may not imply ambivalent longings and strivings.</td>
</tr>
<tr>
<td>First-person perspective: 'I' experiences and phenomenally judges all conflicting longings and strivings as one's own.</td>
<td>A has fully incorporated and integrated B’s perspectives.</td>
<td>Mental health.</td>
</tr>
</tbody>
</table>

Implication for enactive trauma therapy 15:

Healing chronic interpersonal traumatization takes a high level and wide field of consciousness. To help patients and their dissociative parts achieve increasingly higher levels and broader fields of consciousness, enactive trauma therapists consistently strive to collaborate and communicate with them and to model the involved interpersonal skills.
Let us return to Table 1 with the example of part A experiencing, perceiving, and conceiving B’s voice as a thing. Enactive trauma therapists strive to help part A substitute this third-person perspective for a second-person perspective regarding B. To this end, they empathically relate to B as another dissociative part of the patient’s entire personality. Meanwhile, they invite A to notice how they value B, strive to cooperate and communicate with B, and to monitor how B reacts to this relational approach. As a next step they encourage A to start perceiving and treating B as a valuable being, and thereafter to start cooperating and communicating with B. In the same spirit, therapists later help A to start experiencing, perceiving, and treating B as a part of himself or herself. This step involves coaching A to engage in a quasi-second-person perspective regarding B. A final integrative step involves A and B fully sharing each others’ sensations, perceptions, affect, thoughts, memories and behaviors so that A and B eventually become one, implying the enactment of a singular first-person perspective.

Implication for enactive trauma therapy 16:

Enactive trauma therapists propose, invite, and encourage new actions; they do not prescribe them. Enactive trauma therapy is an egalitarian venture. Individuals who have been deeply and recurrently hurt by domineering others are sick and tired of authoritarian instructions.

Therapeutic “dancing.” Enactive trauma therapy is like dancing. It takes pacing, attunement, timing, and sensitivity to balance, movement, and rhythm. It takes courage as well as patients’ growing ability and willingness to engage in new worthwhile actions that therapists may propose and that are within their reach.

Attunement and consensus building. Attunement communicates a deep interest in the patient as the person as well as in any dissociative part’s perspective, longings, and strivings. It leads to the enactment of a consensual experiential, perceptual, and cognitive domain, which implies reaching a higher level and wider field of consciousness. This progression raises patients power of action, as well as the therapist’s, which, in turn, ratifies and deepens the therapeutic bond.

Leading. Enactive trauma therapists invite and encourage patients to engage in creative and effective new actions as steps to recovery and wholeness. They challenge them to take the risk of foregoing fixated action patterns and to tolerate the uncertainty of trying something new in the right measure. A manageable degree of uncertainty is unavoidable, but promotes self reorganization. As Milton Erickson powerfully put it, “enlightenment is always preceded by confusion” and “until you are willing to be confused about what you already know, what you know will never grow bigger, better, or more useful.”
3. CASE EXAMPLE: FRAGMENT OF A SESSION

From the start of a session, Ineke, a middle-aged woman with DID, already five years in therapy with me, shared that she had experienced panic attacks during the past week. The episodes had lasted for hours. They had occurred after ambulances or police cars with howling sirens passed her house. Only long walks with her dog at high pace could calm her down. She did not know why the sirens scared and confused her so much. She just knew that they would surely somehow cause another attack in the future. The attacks almost completely incapacitated her. Something had to be done about these passions, she said. I present here part of our coenacted work during that hour.

Ineke (the predominant ANP’s name) and I first discussed a sensible plan of action. Based on previous experiences, we agreed that one or more of her dissociative parts might know something that she, as Ineke, did not know, more or less. We also agreed that the intense fear and confusion that she experienced might concern longings, other affects, and strivings of one or more dissociative parts intruding in Ineke’s experience. Furthermore, we noted that the matter had become explosive over the last week, unlike ever before. This led us to hypothesize that, inasmuch as the panic attacks manifested intrusion from one or more dissociative parts, these parts were in their own way conveying that the time had come to deal with events that somehow involved sirens.

We decided that it would probably be best to advance with care, given Ineke’s limited power to integrate traumatic memories and strong affects associated with her EPs. Previous work with Ineke had taught us that highly emotional EPs might intrude on her as ANP. In a few cases, confused fragile EPs exerted executive control, making hospital admissions necessary. In light of these passions, it seemed important that Ineke would first get to know the causes of the panic attacks while staying at a mental distance from the involved affects. More specifically, we wanted Ineke as ANP to first observe which (if any) dissociative parts were associated with the sirens and to explore why sirens affected them so much. She might integrate the parts’ affects in a later phase.

Ineke and I agreed to utilize her skill of keeping knowledge, body sensations, affects, and memories dissociated. Inspired by Milton Erickson’s work (1959; Erickson & Rossi, 1979), enactive trauma therapists utilize a patient’s available power of action. By exploring her inner world cognitively, Ineke detected how sirens related to The Little Ones, several childlike and often hyperaroused fragile EPs. The Twins, two adolescentlike ANPs that included some EP-like features, helped her discern this. As before, Ineke experienced that the involved EPs were somehow connected with the left side of her body, whereas she was oriented more to the middle. For example, The Little Ones tended to move her left hand and arm. Several controlling
EPs intruded upon her from the right (e.g., in the form of yelling in her right ear). Ineke as ANP was oriented more to her head, but she also used her right arm and hand.

I suggested to her the idea of using an imaginary remote control to prevent getting emotionally lost in her horrible childhood world. Ineke accepted the idea and practiced the remote control’s functions. However, more help was needed to achieve this goal. She employed the Observer, an ANP-like part, who “only observed and felt very little”, to create a barrier between herself and The Little Ones, whose world was somehow related to the sirens. Under the influence of The Observer, Ineke moved her right hand up and down in front of her as they had often done to keep her emotionally at distance from the fragile EP-world.

With these protective measures in place, Ineke oriented herself to The Little Ones. Remembering now that several controlling EPs had always resisted exploration of traumatic childhood memories, I urged Ineke to consider every part’s longings and strivings. While in low and retracted consciousness, Ineke had disregarded what her exploration meant for the controlling EPs.

With my urging, Ineke discovered that The Reconciler was concerned that a terrible truth would become apparent; however, from earlier therapeutic work, he also understood the importance of searching for it. Ineke felt that she had to “stay in touch with him” while searching. In third-person language, she urged herself to synthesize contrary longing and strivings: hers and The Reconciler’s. The Reconciler strived to keep her from knowing the fragile EPs and their world, thinking of Ineke as being still the young girl she used to be. To ensure Ineke’s (as ANP) survival, he made his role to deny the ongoing traumatization, just as the core and extended family fiercely denied most painful realities.

Ineke had already synthesized, personified, presentified, and symbolized much of the physical maltreatment (by Mother) and emotional abuse and neglect (by Mother and Father), as well as the sexual abuse by someone outside the family. However, she remained uncertain about Father having abused her sexually, despite rather strong indicators of it, but was also disinterested in recovering memories of it.

I suggested to Ineke that she thank The Reconciler for his good work and inform him that she had matured, owned her own house, and had fine friends. I also urged her to send him images of her current looks, home, and friends. Importantly, Ineke added, “that I can make decisions for myself, . . . that family [of origin] is not all, as what he thinks . . . that I must return to them.” Ineke’s statement, in Third-Person Perspective (TPP), revealed an increase of Ineke’s power of action to counter her parents’ and others’ influences. In this instance, she was able to turn her passions into actions.

Myself, I took note of The Reconciler and Ineke as ANP enacting disparate longings and strivings. Directly addressing The Reconciler, I said,
“Yes, Reconciler, your striving on Ineke’s behalf applies to a child. You are absolutely right, that is useful for a child.” I used Second-Person Perspective (SPP) to show to the Reconciler that I understood his perspective on behalf of a child. I wanted to strengthen our relationship, to grow his trust in me, while I also implicitly conveyed to him the idea that the family need not be everything for an adult.

As I spoke, Ineke nodded, right arm still erect, hand next to her head, fingers spread. I thought (TPP) that the tense right hand suggests that The Reconciler continued to be stressed. He could use more support and more time to reflect. Reflection might be a difficult action for him. He seemed to be mostly caught in prereflective symbolic action tendencies. The next step would be to engage him in developing reflective symbolic action tendencies.

E: For a child the family is everything, but what should an adult woman do with a harmful family? [SPP: Invitation to reflect.]

I: . . . and The Reconciler always tries to persuade me that my parents aren’t who I think they are, that they are good, that I am bad, that I am a wicked dirty girl! (Raises her voice, her whole body tenses) . . . I . . . (holds her breath while not speaking.)

E: [(TPP) Ineke shares how The Reconciler tries to make her comply. Compliance is a lower-level action tendency. When both the striving and the danger are high, reflection becomes a very difficult action for a child.]

E: Yes, Ineke, that’s The Reconciler’s way of enabling you to endure that family.

I: It seems that he does not want to accept, he cannot believe that I am an adult now.

E: Yes, show him and tell him, “You may find it hard to accept, you may think it is a pitfall.” Calm him down saying “I am really an adult now, I am not dependent on them anymore. Mother is dead . . .”

E: [(TPP) The Reconciler’s ways, his passions have become fixated. He also seems to fear that accepting Ineke’s current age and life conditions might be a pitfall. Traumatized children have often been deceived with seductive promises that were betrayed later. In SPP, I urge Ineke to reassure him. He lives with her, so to speak, not with me.]

I: She belongs to the sirens. (Spoken in a very decisive tone of voice.)

E: [(TPP) A sudden switch in mode for Ineke as ANP. It is true that I mentioned her mother, but that alone does not explain Ineke’s sudden realization of a connection between mother and the sirens. SPP: I feel she shows readiness to move on. Maybe The Reconciler has become convinced that Ineke has matured and allowed her to move on.]

E: Mother belongs to the sirens. [SPP: Attunement, using Ineke’s words.]

I: They both belong to the sirens.

E: [SPP: Correction. It’s more complicated.]
E: Mother and Father both belong to the sirens.
I: Yes.
[SPP: Consensus.]
E: You and The Reconciler can observe the images. You have the remote control. And do not go faster than either of you can cope with . . .

[TPP: it is important that Ineke increases her power of action in the steps that are presently available to her. SPP: I do not wish to demand more progression than Ineke can currently accomplish, if only because her parents consistently wanted her to do things as a child that a child is not up to.]

From this point onward, with much tension, Ineke started to see images of a traumatizing event. The Reconciler initially screamed in her right ear that the images did not pertain to facts. Ineke described with few words what she observed while making various fitting physical movements and facial expressions. For example, she said:

... being hit in the head very hard . . . because I cry so loudly . . . many images . . . many images . . . a door squeaks very loudly, hinges squeak . . . and then . . . (imitates heavy beating on her head with her right arm and hand, tilts her head forcefully to the left) . . . hitting my head . . . (repeats the movement while she holds her left hand at a slight distance from the left side of her head) . . . my mother . . .

The Reconciler returned in his old role: Whispers, fast, agitated) This is not your mother, this is not your mother, (then louder) this is not your mother.

After reassuring The Reconciler that she could cope with the situation, Ineke continued:

I: (Becomes calmer. Suddenly:) . . . It’s getting dark now (calmer, softer voice).
E: [TPP: It so often happens in trauma work that the achievement of one step almost instantly leads to the activation of another step.]
E: Dark?
I: It’s getting dark (both arms up).
E: Yes . . .
I: A squeaking tone through my ears, a very loud squeaking tone in my head. (right arm and hand move from right to left, several times; tense, very emotional voice.)
E: There is squeaking in your head?
E: [TPP: Why? What is Ineke reporting or perhaps reenacting now? It seems important to watch her closely.]
I: Loud squeaking, in my ear, and then . . . completely black.
E: A squeaking door, your Mother who hits you, squeaking in your ear and head, and then it gets dark . . .
As the session progressed, the traumatizing event became ever clearer:

I: This is . . . this is . . . what . . . happened . . . how . . . how . . . so . . . (Ineke as ANP is very engaged, very emotional.)

[SPP: Ineke starts to own her truth, with every bit of energy and determination. TPP: Her language sounds a bit disorganized, a bit childlike perhaps, but the meaning of her words is clear.]

E: I hear you say, so . . .
E: [SPP: Attunement; making myself present as a witness.]
I: This is how it was . . .
E: [SPP: The Reconciler by his hand and tell him . . .]
E: Take The Reconciler by his hand and tell him . . .
I: This is how it was.

[SPP: Attunement. TPP: Involve The Reconciler. It is important that he joins Ineke in the evolving realization.]

I: This is how it was. Sooo horrible . . .
E: [SPP: Starts to speak in grammatically correct sentences.]
E: This is your reality.
E: [SPP: I rephrase her communication.]
E: This is my truth . . . this is my truth! (Both hands at the level of her chest, moves them in parallel, back and forth, as she also moves her upper body in rhythm.)

[SPP as well as TPP: An act of realization as well as an expression of the need and desire to follow her own conscience. Realization involves knowing something, taking it for real, and taking heed of the implications of this reality. Ineke frees herself from the morals of her family of origin. TPP: There is a balance between the left and right arm and hand, suggesting growing internal balance.]

E: “This is my truth” . . . this is what I clearly hear you saying.
I: Yes!

That is how Ineke discerned the meaning of the sirens. Sirens reminded her of the squeaking door and the squeaking tone in her ears following Mother’s blow. They were also associated with the loss of consciousness, and Father’s “consolation.” As it became apparent later, his consolation had felt good until it turned into sexual abuse, so that the act and idea of consolation gained a horrible meaning for her. Another controlling EP’s name was The Consoler. Ineke reenacted Father’s sexualized utterances and abusive actions as The Consoler, for example, when The Little Ones hurt later in the session. When she briefly touched her left hand (linked to The Little Ones) with her right hand, she startled:

I: Yes . . . no consoling now . . . (hands moved to her head, in parallel, with brisk movements, very stressed) . . . not that . . . but, but (raises her voice, speaks quickly in a higher pitch) I want to tell them they (The Little Ones and the controlling EPs) have all done the right thing . . .
E: Right.
I: ... but, but, no ... no ... no consoling now (hands up, wide apart in the air, almost in a panic)
E: No, no consoling. Tell The Consoler, ah, wait a minute, not those things now ...
I: No, no, ... alright, but no, no consoling. (Moves hands wildly in the air; Ineke is still on the border of panic.)

With more therapeutic work (see Nijenhuis, 2017, Chapter 35), Ineke as ANP became consciously aware that Father had abused her sexually from early childhood until deep into her adolescence. Several fragile EPs had experienced and known this abuse. She realized the full extent of the traumatization by her parents, as well as the deliberate disregard of it by other family members.

4. CONCLUSION

I will close this article by enumerating some of enactive trauma therapy’s principles and practices. Keeping the narrative from the Ineke session in mind should help.

4.1. The Four Features of Trauma-Related Dissociation: Structural, Dynamic, Teleologic, and Phenomenal

As the vignette illustrates, enactive trauma therapists coach patients to turn their trauma-related passions in actions in steps. In most cases, a major goal of therapy is gradual integration of all dissociative parts. That implies integration of traumatic memories that fragile and controlling EPs reenact, that recurrently intrude on ANP, but that ANP has insufficiently integrated. Ineke as ANP and several EPs started to recognize and acknowledge one another, as well as cooperate and communicate. These various parts will eventually comprise a history of chronic parental abuse, maltreatment, and neglect.

Another major goal is to turn the patients’ traumatic relational reenactments into more useful relational patterns. For example, Ineke’s dissociative parts gradually learned to substitute being harmful and adversarial with being useful, appreciative and cooperative. Also, in steps, Ineke as ANP, fragile EPs, and controlling EPs each developed a trusting relationship with me as the therapist.

With each step in these two major endeavors, patients gain power of action and the joy of mastery. With each accomplishment, they become confident for more, so that they may eventually heal and become whole. They attain lasting unity by integrating the traumatic history and learning to manage conflicting longings without reverting to dissociative coping.
To achieve those ends, enactive trauma therapists must continually assess who, among dissociative parts, does what and why. They must explore the following four core features of dissociation provides:

- **Structural.** What dissociative subsystems exist?

- **Dynamic:** What are each part’s passions and actions? How do dissociative parts relate to each other? For example, how do they intrude, avoid, reject, or cooperate and communicate? How do they each relate to other subjects, including the therapist?

- **Teleological (goal-driven):** What are each dissociative part’s longings and strivings and those of the patient as a whole?

- **Phenomenal:** What is the perspective of being a particular dissociative part? What is for each part the meaning of intrusions by other parts? What is it like to be dependent for healing on a person in authority (the therapist) following major traumatization by caretakers, especially if after working with insufficiently trained therapists? What is each dissociative part’s level and field of consciousness?

4.2. Treatment Goals

Enactive trauma therapists coach patients to accomplish what the patient desires, for each session and for the overall treatment, inasmuch as the patient’s longings fit the therapeutic endeavor (Van der Hart et al., 1996). A challenge for therapists is to withhold their personal longings (e.g., a wish to take care of a fragile EP, or to get rid of a controlling EP). With this principle in mind, a useful opening statement is, “What do you long to achieve in this session?”

4.3. Hierarchy of Action Tendencies and Mental Level

Adaptive and creative actions fit the complexity of the situation. For example, sometimes reflexlike actions are sufficient, and at other times reflection is necessary. Chronically traumatized individuals have difficulties in these regards. Typically, patients (as one or another dissociative part) act reflexively, thoughtlessly, with a narrow scope of consequences and with an unduly simple course of action in situations that demand reflective judgment, patience, and complex courses of action. Some belabor intricate options and their potential consequences even when a quick decision is necessary and a simple action are rather harmless. Janet’s writings on the hierarchy of action tendencies (Nijenhuis, 2017; Van der Hart et al., 2006) are a good guide for assessment of patients’ and dissociative parts’ ability to engage in more or less complex action tendencies.
Enactive trauma therapists mind the balance between each dissociative part’s mental efficiency (ability to engage in action tendencies of the right complexity) and that part’s mental and physical energy. Ideally, people choose the level of action tendency and degree of mental and physical intensity that are effective for the desired outcome. For patients who typically reenact a traumatizing event, enactive trauma therapists guide them, instead, about steps of raising their mental level. They invite them to start symbolizing it in ways that are within their current power of action. For example, they may invite the patient to make a drawing of the event. If that works, they may encourage the patient to write down and later name a few features of the event. As a next step, they may stimulate the patient to write down a more inclusive narrative of what happened, which the patient can speak out loud. At some point, Ineke had been able to put the fact of chronic sexual abuse by her father in writing. However, she could not speak the narrative. As she struggled to speak and breathed heavily, I invited her to exhale with the sound of the first letter in the name of the person who had abused her so terribly. With tremendous effort, Ineke sputtered “Ffff...” In that stepwise manner, I coached her next to say two syllables of the word (i.e., Father).

4.4. Embodied Mind and Embedded Person

The terms embodied and embedded denote among other things that each person’s perceptions, conceptions and thoughts strongly depend on "the kinds of bodies we have, the kinds of environments we inhabit, and the symbolic systems we inherit, which are themselves grounded in our embodiment” (Johnson, 1987, p. 99; Lakoff & Johnson, 1999). In other words, a person’s mind reflects possibilities of action with the particular body and in the particular environmental and cultural conditions.

Enactive trauma therapists take embodiment and embedment very seriously. For example, they mind and attune to patients’ body as much as they mind and attune to patients’ mind. They also mind the kind of body-related terms, concepts, analogies, and metaphors their patients use, as well as their nonverbal and paralinguistic expressions. Accordingly, they mind their own embodiment no less. For example, they monitor and adjust how they look (their body posture and bodily expressions), how they move and speak (fast or slow, flat or engaged, loud or soft, etc.). Most of all, of course, they mind the effect of the patient’s and their own nonverbal and paralinguistic communications on each other, for better or worse.

4.5. Egalitarianism

Enactive trauma therapy is an egalitarian, collaborative endeavor. This relational style counters the totalitarian style of typical interpersonal traumatization. It raises patients’ and, if applicable, their dissociative parts’ level of consciousness and widens their field of consciousness.
In sum, enactive trauma therapy comprises the collaboration of two human organism-environment systems: the patient and the therapist. It involves the coenactment of a therapeutic domain that serves to increase the patient’s power of action in daily life. The overall venture is a movement from recurrent reenactments of the traumatic past to enactments of viable present life strivings as an integrated self. Ineke’s case illustrated how laborious it can be to overcome the dissociative parts’ conflicting longings, strivings, and significations and to integrate and realize traumatic memories.

Enactive trauma therapists understand that gaining power of action in therapeutic sessions may not automatically generalize to the enactment of strivings in the real world. Thus, throughout therapy, they encourage patients to apply and test newly gained actions for their strivings in current relationships. For example, patients who have been chronically traumatized by significant others must learn to know whom to trust in everyday life, beyond learning to test the therapist’s trustworthiness. In fact, some satisfactions can be attained only outside the therapeutic relationship (e.g., positive sexuality, shared life goals, academic and vocational achievements). Enactive trauma therapists help patients prepare for all those endeavors. For example, they invite patients to rehearse real-world strivings in therapy and they encourage dissociative parts to convene and cooperate outside the sessions. As gains from therapy generalize to enactment of strivings outside therapy, patients’ power of action increases and they enjoy being an affectively and motivationally integrated self with a meaningful and worthwhile existence.

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