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Response to Commentaries on: Kelly's Circle of Safety and Healing: An Extended Schema Therapy Narrative and Interpretative Investigation

Parts of the Self, Schema Modes, Alters, and Narrative and Pre-Narrative Selves: Understanding and Working With Multiplicity

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ABSTRACT

The account of Kelly's therapy (Edwards, 2022b), and the commentaries by Singer (2022) and Margolin (2022), each, in different ways, highlight the significance of multiplicity, and the importance of understanding it, for the practice of psychotherapy. For several decades, many approaches to therapy have recognized and provided guidelines working with this multiplicity (Hermans & DiMaggio, 2004; Kellogg & Young, 2006; Lazarus & Rafaeli, in press; Rowan & Cooper, 1999; Schwartz, 1997; Stiles, 2011; Teasdale, 1999; Watkins & Johnson, 1982). Schema therapy is an integrative therapy that draws freely on these historical traditions, while offering its own distinctive framework for using multiplicity in case conceptualization for a wide variety of clinical phenomena (Edwards, 2022a). Examination of processes within cases treated within this framework provides the opportunity to further develop and synthesise clinically grounded theory, and, as Edwards (2022b) argued, it is increasingly possible for that practice to be grounded in a scientific understanding of the systems of memory and learning that underlie the client's experience, drawing on the significant advances in our understanding of autobiographical memory systems. This article continues to explore this idea by responding to the commentaries on the case study of Kelly by Singer and Margolin.

Key words: corrective experience; early maladaptive schema; imagery rescripting; schema therapy; schema mode; case studies; clinical case studies

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ON THE THERAPEUTIC RELATIONSHIP

Being explicit about working with multiplicity allows us to understand the therapist's relationship with the client as a set of relationships with the client's different parts. Singer expressed concern and raised questions about "how Kelly's strong parental transference to Edwards played out in all of its meanings and dimensions." The therapist's positioning as an agent of reparenting is a central concept and value in schema therapy. However, reparenting is

directed towards the Child parts, while the goal is to maintain a relationship of mutual respect and collaboration, a therapeutic alliance (Horvath et al, 2011) with the client's Healthy Adult. In Kelly's case there were already strong, well developed Healthy Adult capacities (Edwards, 2022a), which included a capacity for meta-awareness, something that came naturally to her, potentiated by her previous experiences in therapy and a natural capacity for reflection. It was a grounded mindfulness that provided a platform for her to hold the process herself and to work with it actively between sessions. In addition, she had a full and meaningful family and professional life. This contributed to the gathering momentum of the healing process. So, for example, she never contacted me between sessions and did not need to. Of course, many clients have limited Healthy Adult capacities and limited social support or meaningful activity, and therapists may need to actively work to foster and strengthen these in these clients as part of establishing or maintaining a working alliance.

Kelly was clear about what she wanted from the therapy. As she said in the post-therapy interview, "The insight stuff wasn't enough. ... I needed somebody who would push me. ... I wanted to be challenged..." and explicitly and implicitly she had a good understanding of the tasks of therapy we were working on together. The reparenting relationship with her Child is illustrated throughout by the schema therapist's approach to hearing a distressing or traumatic childhood memory. The therapist automatically asks: "What's gone wrong here? What does the child need? What would a good parent do for the child in this situation to meet her needs?" This guides the therapist with respect to promoting an intervention which will provide a direct experience for the client of the child's needs being met, whatever that might involve. This can involve providing protection; naming the neglectful or abusive nature of the parent's behaviour; removing the child from a toxic situation; giving voice and language to unexpressed emotions and experience; offering unconditional acceptance, validation and care; correcting cognitive distortions; and providing guidance and/or support for appropriate claiming of autonomy. Kelly was particularly appreciative of my putting into words the unvoiced experience of the child (Edwards, 2022b, p. 235).

On page 245 of Edwards (2022b), I relate this therapist stance to Winnicott's concept of the holding environment which I describe as "an interpersonal space where protective figures offer care and where specific needs can be understood and catered for." However, although the therapist may offer such a holding environment, the client may not be able to fully receive it. In the first part of the therapy, Kelly was conscious of using my interventions to support her adult self in reparenting the distressed child figures that emerged. It was a matter of "teaching me to reparent myself" (Younan, Farrell, & May, 2018).

An important aspect of my stance as a therapist is captured by a distinction between the metaphors of therapist as carpenter, and therapist as gardener, suggested by Bohart (2021), following Gopnik (2016). The carpenter assembles and constructs. The gardener prepares the ground and creates the conditions for plants to grow optimally, but the growth and its trajectory

come from within the plant. The gardener metaphor is implicit in Rogers' (1961, p. 84) account of the therapist's relationship to the client as

> caring enough about the person that you do not wish to interfere with his [sic] development, nor to use him [sic] for any self-aggrandizing goals of your own. Your satisfaction comes from having set him [sic] free to grow in his [sic] own fashion.

Gopnik applies this to parenting:

> Our job is not to shape our children's minds, it's to let those minds explore all the possibilities that the world allows. Our job is not to tell children how to play. It is to give them the toys and to pick up the toys again after the kids are done (cited by Bohart, 2021, p. 8).

Kelly herself came to appreciate this when she expressed concern about whether someone should be actively helping the children in the circle. She considers how it is fine to just leave her own son to play by himself (Edwards, 2022b, p. 230). He is in "a good space" because he knows that "when he starts to yell for a sandwich somebody will provide, and, in the meantime, he'll just do his thing."

This is how I experienced working with Kelly. Using Elliott and Greenberg's (2007) metaphor of following and leading in a dance, there were times when I firmly and clearly led, but I was also attentive to the ongoing process, concerned to understand it and support it in its dynamic unfolding. Following Bohart (2021, p. 16), I see therapy as drawing on "an intrinsic growth tendency," such that

> when the organism is not turned against itself, it will spontaneously move to a better personal organization and better organized interface with the world to meet the needs of the person better.

Fosha (2009, p. 175) is particularly explicit about this potential for healing:

> Deep in our brains, there for the awakening and activation in facilitating environments, lodge wired in dispositions for self-healing and self-righting.

When activated by an experiential therapy process, this gives rise to what she calls transformance:

> It is not just that attachment injuries are healed, trauma transformed or depression lifted. … [Transformance gives rise to] the activation of new resources and capacities which could never have been imagined much less predicted at the outset (Fosha, 2009, p. 201).

After about 50 sessions, Kelly moved from allowing me to teach her to reparent herself to engaging with the need to fully trust me and to let in my care for her directly to the Child. This

led to a significant shift. As she said in the interview: "It was kind of a bit freaky for me to feel that this might be genuine, that I might be genuinely cared for." This is the same experience that Rogers (1961, p. 81) reported in his classic case of Mrs Oak. In session 30, Mrs Oak expresses a similar surprise:

> I found out that you actually *care* how this thing goes (both laugh)... It suddenly dawned on me that in the client-counselor kind of thing you *actually care* what happens to this thing. And it was a revelation.

For Kelly, this was an important step that allowed for a deeper level of process and healing that gave rise to the healing circle and all that followed from that. Although I had been offering this from the beginning, Kelly only fully accepted it at this point.

Singer also expresses a concern about "gendered and paternalistic elements" of my role. However, this is, I believe, a misunderstanding. The maternal and paternal functions of a parent towards an infant and growing child are not necessarily limited by actual gender or biological relationship (Davies & Eagle, 2013). From the perspective of attachment theory, the maternal function is about nurturance and unconditional care, while the paternal function involves protecting the safety of the safe haven, which serves as the secure base from which the child can autonomously venture into the world, and to which he or she can return from such a venture to "refuel" (Wallin, 2007). In this, the paternal function is also to support the child's autonomous ventures that involve separating from the mother, while offering guidance and protection to ensure the child's safety while away from the base. Winnicott's holding environment has both aspects and Winnicott's accounts of his therapies attest to the depth of maternal care he offered, that was not limited by his gender.

Rescripts in which the therapist provides protection by confronting the mother and/or father with their failure to meet the needs of their child, often provide great relief. Kelly experienced this protection directly. As she remarked in the interview, "in terms of telling my parents off—that kind of stuff—I've never experienced anybody who's been prepared to do that." An example of the healing impact of this, not included in the Kelly narrative, occurred after session 22. In imagery, I had confronted her terrifying mother and had frozen her. In the week following, she spontaneously saw the child Kelly, who, before that, always played alone in her room, coming out and playing in all the passages and rooms of the house—steadily making them her own. This process continued at home after session 23 as well and is another example of the generativity and creativity of Kelly's own process which I was enabling in a manner that is well captured by Gopnik's gardener metaphor.

This understanding of the maternal and paternal functions allowed me to be comfortable with the fact that Kelly's healing circle included only men. This was not something of my making. In terms of the dance metaphor, in this I was following, not leading. The circle spontaneously emerged from Kelly's own imaginative process. When I suggested that the kind

neighbour Diane be included, Kelly was clear that she should not. Once in the circle, the child parts were protected and unconditionally accepted, and she saw them as actively playing and interacting with each other there. However, this was not enough for the unborn part. This needed a kind of maternal care that the men could not offer, and it was then that she recognized that her Adult self could offer that. This did not involve her taking a place in the outer circle but entering the circle as one dedicated to meeting the particular needs of the unborn part which only a mother could do. As she expressed it, she could do this because of the protection provided by the men who made the circle, a pattern that is archetypal.

THE DUAL MEMORY SYSTEM AND ITS CONSEQUENCES

Singer (2022, p. 263) points to some differences between us in the way we would understand the phenomenology of Kelly's experiences, as described in the case narrative, in relation to Conway's theory of autobiographical memory. The problem, as I see it, concerns the way that the two parts of the dual memory system, the episodic and conceptual, relate to each other. The challenge of understanding this goes back to at least a century before Freud, when the German poet Schiller (1759-1805) emphasised the importance of accessing the unconscious, and "advised a friend to release his imagination from the restraint of critical reason by employing a flow of free associations" (Whyte, 1962, p.129). Whyte cites Schiller's remarkably prophetic words:

> Although by the dim light of everyday emotions, the secret workings of the forces of desire remain hidden away from the light, it becomes all the more conspicuous and stupendous when passion is strongly aroused… If, as for the other realms of nature, there would arise a Linnaeus to classify impulses and inclinations, he would greatly astonish mankind.

Over two centuries later, this project is well underway, the work not of one Linnaeus but of several clinicians and researchers. Singer helpfully cites Tomkins' analysis of scripts, and Demorest's (2013) linking the concept to similar concepts in several theories of psychotherapy, including that of schema therapy. Demorest usefully points to several theorists who have been mapping these experiences and finding ways to catalogue them in terms of particular themes or patterns in scripts, schemas, internal working models, etc. The concept of script is also central to Transactional Analysis and Edwards (2007) pointed out how many features of the way schema therapists understand schemas and corrective experiences were clearly stated by such authors as Erskine (1997) four decades ago. Although in schema therapy, the term script is mainly found in reference to the technique of imagery rescripting, the sequence of states found in scripts is well recognized and referred to as mode sequences (Edwards, 2020, 2022a).

At the birth of psychotherapy, free association, hypnotic inductions and other methods were employed to bypass "critical reason" and connect to "the forces of desire," to use the language of Schiller (above). Today various forms of emotional and somatic focusing and the

affect bridge can help us achieve this more systematically. These are ways of engaging with what Conway (2009) calls the episodic system, and Teasdale (1993) the implicational.

With respect to episodic memories, it is important to differentiate between the experience of retrieval and the underlying memory structure itself. Singer (2022, p. 266) is referring to retrieval when he states that "episodic memories are mostly ephemeral and are seldom retained over time." He observes that if episodic memories are repeatedly recalled they can start to take their place within the narrative of the conceptual self and the life story. However, those that are not so retrieved do not disappear. Conway (2009, p. 2309) notes that there are different degrees of accessibility, "ranging from the highly accessible to the inaccessible (but still available)."

Furthermore, the episodic/implicational system has its own internal structure. This is the domain of Bowlby's internal working models, which were reframed by Lyons-Ruth et al (1998, p. 285) as patterns of implicit relational knowing. This "encompasses normal and pathological knowings and integrates affect, fantasy, behavioral, and cognitive dimensions." These knowings are independent of the language-based encoding of the conceptual self and

> typically operate outside focal attention and conscious experience, without benefit of translation into language. Language is used in the service of this knowing but the implicit knowings governing intimate interactions are not language-based and are not routinely translated into semantic form.

As Edwards (2022a, p. 2), observed, it is these underlying "organizational unit[s]" that are the basis for an individual repeatedly exhibiting "the same cognitive, emotional and behavioral pattern." The scripts are part of this system, for, as Conway (2009, p. 2305) observes, the episodic system contains abstracted patterns that are "more representative of an experience than … a literal record."

It is therefore a mistake to place scripts or early maladaptive schemas within the conceptual self as Singer et al (2013) appear to do, in calling them "narrative scripts." Many of these scripts remain in the implicational system and are lived pre-reflectively and merely enacted. They are not necessarily part of the explicit domain of the conceptual life story. They will only become part of the conceptual self and the life story if they are spoken about and reflected on.

This translation of an implicit script into language can take many forms. Research with the Adult Attachment Interview shows how adults with secure attachment provide a life story that is coherent and insightful and psychologically accurate. This points to the role of good parenting in teaching children how to use language to understand emotions and psychological states. However, those with dismissing attachment provide little detail and limited insight and memories are overgeneral, and there is a lack of coherence in the stories of those with preoccupied and unresolved attachment patterns (Bakermans-Kranenburg & van Ijzendoorn,

2009). Thus, Bendstrup et al (2021) found low coherence in the autobiographical memories of those with borderline personality disorder. One of the effects of psychotherapy is to facilitate the integration of memory material that is still in the implicational or episodic system into the conceptual self and life story. Levy et al (2006) found that coherence in the adult attachment, which was low in clients with borderline personality disorder, increased after a year of Transference Focused Psychotherapy, with many participants moving from the insecure to the secure category. There was accompanied by an increase in reflective functioning.

Recognition of the dual memory system is central to understanding the experiences of clients with posttraumatic stress disorder. A traumatic memory (episodic), even a recent one, does not easily become integrated into the narrative of autobiographical memory. As Ehlers and Clark (2000, p. 325) point out, "the trauma memory is poorly elaborated and inadequately integrated into its context in time, place, subsequent and previous information and other autobiographical memories." This means that it is not incorporated into the conceptual self as a narrative. The episodic elements remain in storage and when triggered, result in flashbacks in the form of images and emotional and somatic states that are intensely distressing. Thus Conway (2005, p. 612) recognizes that

> The fear and anxiety associated with looking at oncoming car headlights prior to a major RTA [road traffic accident] may be literally represented in an episodic memory of the experience ... There may even be very specific representations of motor movements.

The treatment that follows from this, focuses on helping clients re-experience the episodic memories, while retaining the capacity to keep some distance and reflect (meta-awareness). A range of interventions, including imagery rescripting, are used to modify the distressing and overgeneralized meanings associated with the trauma memory. This facilitates the integration of the memory of the event into the conceptual self, so that it becomes part of the life story. The client moves to recognizing that the trauma is in the past and not happening now (Ehlers, Hackmann, & Michael, 2004). The therapy based on this has been shown to be particularly effective in treating PTSD (Ehlers, et al, 2005).

However, intense intrusions from episodic memory may not be recognized as flashbacks at all. "Schema" in schema therapy, is short for "early maladaptive schema" and refers to patterns which include overwhelming primary emotions and ways of coping with these that often have their origins in early childhood and infancy. When triggered in the present, the emotions and somatic symptoms that are experienced may be episodic elements of a traumatic memory that are being relived in the present, in the absence of an explicit memory of the primary trauma. This applies not only to memories of life-threatening trauma, but to overwhelming experiences associated with primary schemas such as abandonment, emotional deprivation, mistrust/abuse, failure and defectiveness.

The role of psychotherapy in uncovering unrecognized early memories of events that were emotionally overwhelming is widely recognized. An experience of abandonment in infancy or early childhood may give rise to an intense fear of abandonment in adulthood without the individual being aware of the memory underlying the intense emotion. Hackmann (2005) describes how she helped a woman in her 40s to uncover the source of a fear of abandonment and helplessness that had resulted in her being agoraphobic for 20 years. Although she would have vivid catastrophic images of being abandoned in the present, it was only through careful investigation in psychotherapy that the source of the intense emotion was located—an event that happened at four years old when she was forcibly hospitalized. The case of a 12-year-old boy who was acting with intense terror and hostility and facing psychiatric hospitalization provides a similar story. Through careful investigation, and guided by a dream, the source of the boy's trauma was uncovered as an event that had happened 6 years earlier when he was forcibly held down by nurses and given an injection at a hospital (Raby & Edwards, 2011). In these cases, the emotionally charged episodic elements of the primary memories had not yet been integrated into autobiographical memory as a coherent narrative and the therapy focused on facilitating that integration.

What is experienced in the present, in response to triggering, may also be a coping mode that obscures the primary emotion, for example, an experience of victimized self-pity, or of helplessness, a mode which schema therapists call "helpless surrender" (Edwards, 2022a), or an experience of defeat and giving up, something identified by Ehlers et al (1998) as particularly potent in preventing emotional processing of distressing memories. When this happens there may be a conscious narrative around helplessness or being a victim, but this is only partial as the primary trauma may not be recognized at all, let alone incorporated into the narrative.

NARRATIVE AND PRE-NARRATIVE IDENTITIES

Recognizing that underlying patterns (scripts, schemas etc.) in the episodic system may be more or less rendered in language and integrated into the conceptual self allows us to revisit Singer et al's (2013, p. 572) concept of self-defining memories. These are "vivid, affectively intense, and well-rehearsed" and "reflect individuals' most enduring concerns (e.g., achievement, intimacy, spirituality) and/or unresolved conflicts (e.g., sibling rivalry, ambivalence about a parental figure, addictive tendencies)." Having been well-rehearsed they are available to awareness and reflection and seem to have become part of the life story. However, their affective intensity means that the underlying emotions in the episodic system have not yet been fully emotionally processed and they have not yet been maturely elaborated into the conceptual self.

I suggest that there are three levels to what Singer calls "narrative identity." The first is a pre-narrative level at which there are experiences for which there is no narrative. This may result from the failure of parents to attune to the child's experience and guide the process of putting experience into words, which, as we will see later, has a significant impact on the narratives that

develop. However, it can also result from the dissociation of overwhelmingly traumatic experiences. This gives rise to what Browne (1990, p. 90) called "unexperienced experience." This results from the fact that "the processing of experience can be blocked at an early stage and the inchoate experience can remain in this state for months, years, or indefinitely." When this happens, episodic elements that come to awareness are experienced as confusing and alien intrusions. As already mentioned, this understanding provides the theoretical basis for the trauma focused therapies, which Ehlers and Clark (2000) link explicitly to Conway's model.

In contrast to the pre-narrative level, the conceptual life story of Conway's model is a coherent narrative (or interlocking set of narratives) without affective charge. Such narratives are realistic, and, when psychologically insightful, and told with meta-awareness and absence of identification with the painful predicaments of past events, would reflect schema therapy's Healthy Adult (Edwards, 2022a); Dweck's (2006) growth mindset, or Baltes and Staudinger's (2000) wisdom.

However, in between these two extremes are schema-driven narratives that reflect the action of early maladaptive schemas that have not been resolved or healed. There are three kinds of such narratives depending on the predominant coping style. First, detached/avoidant coping, resulting from the failure of parental attunement referred to above, gives rise to very restricted and simplistic narratives associated with lack of detail, overgeneral memory, and absence of psychological insight. Second, overcompensator narratives dismiss, minimize, and suppress the painful emotions of the early schema level by creating an identity that may be overly optimistic and/or self-aggrandising. The former is well illustrated by Alexandra Fuller's (2015) account of the personality of her mother, who

> … painted life gilded, she skipped over the difficult bits, and she put a positive spin on Rhodesia's long and bloody civil war ("Best years of my life!"). She repeated her favorite stories over and over like church, and I think for the same reason. The more often you say something, the more likely it is to affirm itself, to become an accepted truth, and to evolve into a communal memory.

Schema therapists call this a Pollyanna overcompensator (Edwards, 2022a; Simpson, 2020), and elsewhere it is often referred to as toxic positivity (LeCompte-van Poucke, 2022).

Other overcompensator narratives tell stories that enhance the dignity of the individual or the individual's place in life. This is well illustrated by two characters in Ishiguro's (1995) *The Unconsoled*. The hotel porter, Gustav, goes to great lengths to explain how he takes pride in carrying heavy suitcases without putting them down, even when he could. He is part of a hotel porter's community that celebrates the dignity of their occupation by meeting regularly at a café. Here, at times, they perform a ritual porters' dance during which they hold up deliberately overloaded suitcases, an activity that eventually contributes to Gustav's death from a heart attack. The hotel manager, Mr. Hoffman, goes to great lengths to assure himself that his guest

has a comfortable bed: "I ask because we do pride ourselves on our beds. We renew our mattresses at very frequent intervals. No other hotel in this town renews as many mattresses as we do. This I know for a fact." However, he is not actually listening to his guest, and this is part of a long narrative monologue. The emotional disconnection of this mode is confirmed when, later, we learn how desperately lonely Mr Hoffman's wife is.

Third, surrender coping gives rise to two problematic kinds of narratives. Compliant and rescuer narratives may enable the individual to disconnect from underlying distressing emotions by focusing on the needs of others. By contrast, victim narratives are associated with painful memories that are clearly remembered (or reconstructed) and still retain their affective charge. Self-defining memories belong here. These narratives may portray helplessness and/or self-pity in the face of neglect and abuse, and are associated with the cognitive distortions of Beck et al's (1979) cognitive therapy and Dweck's (2017) fixed mindset. These are often rehearsed in various forms of chronic rumination (Edwards, 2022a) of the kind that characterises clinical depression (Papageorgiou & Wells, 2004; Watkins, 2016), complaining and embitterment (Linden & Maercker, 2011).

In schema therapy, the schema-driven narratives of the coping modes each call for particular kinds of therapeutic work. For Overcompensator and Detached modes, the challenge is to get past them to access the early maladaptive schemas in the episodic/implicational system which the coping disconnects from. Detached modes are particularly challenging as they may have very little in the way of narrative articulation for the therapist to engage with. Surrender modes also disconnect. Self-sacrifice coping, especially when blended with a self-satisfied self-aggrandiser, may, like overcompensator modes, disconnect from the underlying schemas entirely. Those that exhibit helplessness, and self-pity/victim narratives provide a window into the underlying schemas, but access to primary emotions in the episodic system may be blocked by self-consciousness and various forms of repetitive unproductive thinking (rumination, worrying etc. Edwards, 2022a).

This means that we can expect to encounter coping modes with underlying scripts at different stages of narrative development. The socially crafted coping identities of Mr Hoffman and Gustav, for example, have a high level of narrative articulation. Some coping modes, however, may have only a limited narrative articulation. These modes, which I call coping child or protector child modes (Edwards, 2017, 2020, 2022a), form in childhood and remain in place and are elaborated in adulthood. These may continue to have a high degree of automaticity and their scripts may only be clearly articulated into language as part of the therapy process. Kelly's mode that "always managed things by ... working out what is required from me in order to fit in or belong" (Edwards, 2022b, p. 227) is an example of this.

Singer's self-defining memories occur when such narratives coalesce around one or more particular events. However, the critical events in self-defining memories are not be the first occasion in which an underlying schema or script was played out. Feeling defective and helpless

on being bullied at school can be a replay of an existing schema pattern founded on memories of earlier experiences of neglect, subjugation and emotional abuse at home. These early patterns can become fixated in the sense that, when re-activated, the experience is of a child at the age at which the schema formed. If we enquire into the experience of a child being bullied at school, we often find feelings of helplessness and shrinking that allow us to bridge back to a much younger stage. This is illustrated in the Kelly case material, when in session 51, the terrified toddler and her sister are imaginally taken to the safety of Diane's home. At this point, Kelly "sees a kaleidoscope of images of Little Kelly from an infant in arms all the way up to the three-year-old" (Edwards, 2022b, p. 221). This suggests that the memory of the toddler's terror and seeking to hide was incorporated into a schema that was already established in infancy.

This is the rationale behind the concept of triggering and use of the affect bridge to go back to earlier memories. Erskine and Zalcman (1975) appropriately use the term "reinforcing memories" for later events that seem to provide further evidence for beliefs incorporated into earlier schema patterns. Scripts or mode sequences in well-recalled self-defining memories may have their origins in much earlier schema patterns. These earlier patterns shape the experience of distressing events in middle childhood or adolescence but may still remain in the implicational system, making it difficult to fully resolve the conflicts embedded in the later self-defining memory.

THE CHALLENGE OF DISSOCIATION

Human multiplicity is in part due to the need for different scripts for different situations (an office, a place of worship, a swimming pool, a bedroom etc.), but the problematic emergence of multiple selves, often in conflict with each other, is due to overwhelming emotions associated with unmet needs and trauma. In a chapter entitled "The everywhereness of trauma," Howell and Itzkowitz (2016, p. 36) observe that

> The mind is structured dissociatively … [there is] a multiple self-structure … in which trauma, which is, to a greater or lesser degree, endemic to everyone, leaves its mark in dissociative structure.

This means that dissociative processes are inevitably encountered in most psychotherapies. Margolin (2022) notes that although they are particularly prominent in dissociative identity disorder (DID), the kind of dissociation seen in Kelly's therapy process is structurally very similar.

Margolin's commentary (2022) highlights two of the challenges for therapists of extreme degrees of dissociation resulting from severe ongoing neglect and abuse. The first is that the parts are dissociated from one another, each offering different ways of viewing and responding the world, that inevitably conflict, often creating severe confusion and distress. In DID, in particular, they may be so clearly defined as to seem like alternative personalities or alters. Here,

the therapist must, using methods that Margolin describes, seek to promote meta-awareness in the client, building a central executive that can stand outside and disidentify from all the conflicting parts, a feature of what schema therapists call the Healthy Adult (Edwards, 2022a). In contrast to Margolin's case examples, Kelly began the therapy described in the case study with an already well-developed capacity for meta-awareness, noted by Edwards (2022b, p. 219) and further discussed above. This provided the basis, as Margolin implies, for promoting dialogue between the parts with the goal of helping them work together rather than against each other.

The second aspect of dissociation, discussed above, is the blocking of memories of overwhelmingly unbearable experiences which makes the individual vulnerable to flashbacks when triggered by specific cues. These flashbacks may be recognized as such, particularly when the client has been trained to do so by a therapist. However, they may just be experienced as intense emotional states without any time reference and this is particularly confusing for client and therapist alike. Margolin's client, Anna, had learned to recognize the intensely distressing body sensations and emotions she sometimes experienced as "body memories" related to childhood experiences of severe neglect, abuse and emotional deprivation, and, in due course, to find and experience safety and care in the imaginal circle of support that the therapist helped her create for herself.

At the start of her therapy with me, Kelly was psychologically minded and able to offer an insightful narrative about her life including the events of her childhood. This had been achieved with the help of her previous therapy and her ongoing capacity for mindful reflection. However, much of her experience was still excluded from this narrative, experience that she would engage with in the therapy, and that would take her to painful memories and schema patterns many of which were still at the pre-narrative phase. Kelly's experience of these as a number of distinctive child selves is particularly pertinent to our understanding of the way that the implicational level is structured.

KELLY'S MULTIPLE CHILD SELVES

Kelly's multiple selves or modes included her Healthy Adult, the child selves that came into focus and eventually entered her circle of safety as well as several coping modes familiar within the schema therapy literature. Some of these were blended modes (Edwards, 2022a) like the responsible self-sacrificer that "always managed things by ... working out what is required from me in order to fit in or belong" (p. 21). This is primarily a surrender mode with a focus on attending to and meeting the needs of others, but with this are blended overcompensatory features such as a strong and independent self-sufficiency, and an over-responsible hypervigilance. This latter element came into focus in session 60 as a self-critical and demanding voice that tells her: "You can't afford to let things slip … You can't go around being flexible" (Edwards, 2022b, p. 228)." Another mode is scolding and judgmental of others. Another is the detached self-soothing Kelly who plays alone in her room, absorbed in the process of her game.

The child selves that entered Kelly's the circle of safety are child modes that had become fixated. That is, their development has been arrested in the face of overwhelmingly painful emotions. Each child has the qualities and memories of the child at the point of fixation, and its own distinctive script or schema pattern, each with its own "implicit assumptions for anticipating and dealing with life experiences so as to maximize positive emotions and minimize negative emotions" (Demorest, 2013, p. 583). Before the therapy these were largely pre-narrative identities, part of the implicational system, and were not self-defining in the sense that they had not, till now, been "well-rehearsed." They were not yet part of the languaged narrative of the conceptual self.

Kelly's embryo mode was entirely at the pre-narrative stage. Her experience of herself as an 8-year-old, having a strange derealization experience, makes sense if we accept the existence of prenatal templates. The experience that she initially put into words as being in a bubble, can be understood as a flashback to a prebirth trauma, still recorded in episodic memory, a trauma that she was able to put into words, make sense of, and address through the therapy process.

Singer expresses reservations about the possibility of memory going back so early, particularly before birth. Recognizing the longstanding debate within which Singer's scepticism is widely shared, Edwards (2022b, pp. 244-245) reviewed the increasing evidence that has eroded the grounds for that scepticism. All attachment-based psychotherapies are founded on the recognition that problematic schemas can go back to infancy at least, and for object relations therapies this is foundational (Celani, 2010; Lyons-Ruth et al, 1998; Rubens, 1994).

Note that Singer's (2022, p. 268-269) specific wording is the urging of

> caution about how far "empirical psychology" has come in validating the contributions of implicational infant and early childhood memories to the unfolding of maladaptive schemas.

In my view, this is a distortion of the meaning of the word "empirical," which refers to a theory or conclusion that is based on data from the world and is not purely deduced on theoretical grounds. Mainstream science has hijacked this word to limit the data from the world that is regarded as relevant or valid, and largely excludes the kind of qualitative, experiential data that is central to psychotherapy and much qualitative research. This is simply prejudice and it comes from a position from which, if we took it seriously, we would have little basis for understanding many important processes in psychotherapy at all. As Richard Feynman is alleged to have said, "I would rather have questions that can't be answered than answers that can't be questioned." He certainly wrote about science being open-minded in the face of uncertainty and the unknown. If we rule out this kind of experience in the service of being "scientific," we risk doing harm to our clients who access this level of memory.

Memory material from infancy and pre-birth is regularly reported by therapists. Rucker (1998, p. 73) gives several examples and suggests that prenatal experiences are understood to be

"formative templates for later experience and relatedness" and the clinically relevant examples of Findeisen, Kalef, Grof and Piontelli were referred to in the case study paper (Edwards, 2022b). In my own experiences as a therapist and supervisor, several clients have described what appear to be memories when they were still sleeping in a cot (probably the first 18 months of life) and other cases where there seemed to be regression to distressing pre-birth experiences. Many early maladaptive schemas are likely to have their origin in infancy and even before. The fact that so far research has not discovered a clear mechanism for these memories is not a reason for ignoring them.

During this early period, the fetus or infant is particularly vulnerable to overwhelmingly distressing emotions resulting from fundamental needs not being met, and the limited capacity to regulate intense emotional states. A newborn, programmed to expect and respond to attuned loving care, may be disappointed and shocked when that care is not provided. The response is what Erskine (1980) calls "cognitive closure" which is "the child's explanation to himself or herself as to why the need was never satisfied (i.e. "Something is wrong with me") and/or determines how to protect him or herself (i.e. "I'll get hurt if I ask for what I want"). This would create a script whose memory basis is not available for recall, and which may or may not be integrated into the explicit narratives of the conceptual self. For the schema therapist this would be a defectiveness schema, which, at the beginning of therapy, many clients are aware of, but which many others are completely out of touch with.

Childhood amnesia, the widely recognized difficulty most people have in recalling memories from infancy up to the age of around 5, is not the result of there being no mechanism for remembering. Conway, an experimental researcher, not a psychotherapist, argues that memory is active in infancy: "The emerging evidence from neuroscience [for] a heavily sensory–motor and unconscious registration–retention network in the infant" (Singer & Conway, 2011, p. 1193). "Because infants have goals," write Conway and Pleydell-Pierce (2000, p. 278), "it follows that infants retain durable autobiographical knowledge relating to their goals." Childhood amnesia is the result of problems with retrieval. The working self accesses the memory system on the basis of current goals. Conway (2005, pp. 602-3) writes,

> The goals of the infant and young child, through which experience is encoded in memory, are so different, so disjunct from those of the adult that the adult working self is unable to access these memories.

The same would apply to memories recorded *in utero*, for the existence of which there is now a huge amount of experimental data, already briefly reviewed in the case study article.

CORRECTIVE EXPERIENCES AND MEMORY RECONSOLIDATION

In discussing the Kelly narrative, I suggested that Estes' (2005) concept of the theatre of the imagination is helpful here. Creating this can be understood as

> a specialized activation of the theater of consciousness in which access to episodic memory, with its range of emotional valences, is heightened, and Conway's Remembering-Imaging System is activated (Edwards, 2022b, p. 241-242).

This raises the question posed by Singer about the relationship between Kelly's images and actual memory. Singer comments (2022, p. 269) that, "This treatment is based as much in imaginative vision as it is in memory."

Bowlby's "working models" are built up out of experiences of specific events (memories) to create an abstracted understanding of how the world works. However, because of the developmental changes in the journey from infancy to early and middle childhood, and on to adolescence and adulthood, individuals will continually encounter new ways in which the world works. In addition, the cognitive technology available for representing the world changes and becomes more differentiated with the unfolding of the developmental stages, as brought to our attention by Piaget. We see this in two of Kelly's Child selves: the 3-year-old peacemaker is at an earlier level of cognitive/emotional development than the 7-year-old self-sacrificer.

The working models that guide our perception and actions need to be updated and elaborated on an ongoing basis. In many cases, this happens. The psychologically healthy adolescent negotiates relationships with very different patterns of implicit relational knowing, than in the past when an infant or child. However, when conditions have not been ideal, and important needs have not been met, the working models fail to be updated with new information. A related problem is that, for children faced with unpredictability and inconsistency, there may be several working models running in parallel, dissociated from each other. Object relations theory and therapy is founded on the perspective that an adult's interpersonal relationships, particularly intimate ones, may still be guided by internal working models left over from infancy or early childhood, often in conflict with each other.

This means that one of the tasks of therapy is to help the client identify and understand these obsolete working models, and to update and integrate them. This updating has two aspects, The first is the move from the simplistic cognitive technology of an earlier system (characterised, for example, by such features as all-or-none thinking, or magical thinking) to the more complex technology available in mature development. This is the basis of cognitive restructuring in cognitive therapy which, in schema therapy, is part of the work of building the Healthy Adult. The second is to separate past from present, particularly where the adult individual is in relationships very different from those that characterised their infancy and early childhood. Here

the individual is helped to learn that the working models based on parents who were neglectful, unpredictable, abusive, overprotective etc do not apply to current significant individuals in the person's life.

The kind of imaginal emotion-focused work described in the Kelly narrative is intended to activate such obsolete working models and to promote corrective experiences that update them and bring them into line with the reality of the client's current life and relationships, as well as to develop and strengthen the mature capacities available to the individual, as an adult, that were not available in earlier developmental periods.

While the therapist is interested in particular memories as traumatic episodes that could not be processed and integrated at the time, or, as examples of underlying schema patterns, it is the working models that are the main concern, rather than the specific events from which they were initially abstracted. With the appearance of the circle of safety, in Kelly's unfolding process, and the series of child selves who appeared and were invited into it, there was a significant shift from working with specific memories to working with a finite number of child parts with specific complex scripts. At the same time, it is probable that specific remembered events did happen: Kelly's mother did react with horror at discovering she was pregnant; at three years old, Kelly did desperately try to help her distressed mother by trying to get her to swallow some pills that she believed would calm her down; Kelly did hide under the table in terror of her mother's rage; Kelly did believe that her mother might kill Sarah when she saw her frog-marching her out of the room, and so on. The title of Singer's (2022) commentary, "the reconstructive play of memory" and his reference to "imaginative vision," point to the fact that the therapist is less interested in whether the details of a memory are accurate, than in the relational predicament in which the child is trapped, and what will be required to create a corrective experience.

There is ongoing debate about whether this results in the old working models being reprogrammed and reset or whether they simply go offline, and are replaced by new, more accurate and differentiated ones. In the case study article (Edwards, 2022b, p. 249), several leading authors are cited who argue that neuroplasticity allows for a process of memory reconsolidation which serves as a basis for deep and permanent healing of early maladaptive schema patterns.

NURTURANT TOUCH AS A CORE NEED

Margolin (2022) gives two examples of "direct nurturing," holding the hand of client who is reliving a trauma or experiencing intense distress. She describes this as "a controversial intervention that extends traditional limited reparenting and imagery" (p. 278). However, this kind of facilitative touch is widely practiced among psychotherapists of many different orientations. I recall seeing video recorded sessions by hypnotherapists at conferences decades ago in which the therapist held the hand or placed a hand over the hand or arm of a client. Part of

the reason this might be considered controversial is because of what Swade (2020) calls "the touch taboo in psychotherapy," something she thoroughly and admirably examines in her book with this title. Swade (2020) includes a chapter that provides clear guidelines for negotiating with the client about the use of physical touch to ensure that the client is fully involved in the decision to employ it, and Margolin's description of her use of direct nurturance, seems to fully accord with those guidelines.

Swade shows how the touch taboo has several roots, including the traditional abstinence in meeting clients' needs that Freud and his direct followers recommended. However, even within psychoanalysis, this approach has long been questioned. Introducing a special issue of *Psychoanalytic Inquiry*, on touch in psychotherapy over two decades ago, Fosshage (2000) made a strong case for a more open and balanced approach. He cited well-known examples from Winnicott and Kohut and wrote,

> Psychoanalysts of different persuasions in private … will frequently comment that physical contact in the way of handshakes, handholding, hugs, and squeezes on the arm occur and are experienced by both analysand and analyst as facilitative (p. 22).

He adds,

> Touch undoubtedly occurs much more frequently in the psychoanalytic arena than has been reported. In my recent private poll of approximately 30 analysts, every one had hugged or been hugged by patients (p. 29).

Swade (2020) reported a similar poll but of clients who had experienced touch during their therapy. Of the 30, all but three reported positive experiences and Swade offers a useful account of the various themes relevant to these positive experiences. The other three experienced touch as intrusive and unwelcome and this was, in part, related to what is widely recognized, that physical touch can be painfully triggering for many clients with a history of sexual and physical abuse.

In an early examination of this issue (Edwards, 1981), I pointed out the obvious distinction between nurturant and sexual touch, and like many of the authors referred to here, cited Ashley Montagu's seminal work on the importance of touch in human development, particularly in infancy and early childhood. Few approaches to psychotherapy today are not based on an understanding of attachment theory and the needs of infants and children as they grow. Within this framework, the need for nurturant touch cannot be ignored.

This has long been recognized by many humanistic and body-oriented therapies and, decades ago, at a holotropic breathwork workshop, I recall seeing the group leader directing two group members to lie on either side of a group member who was in a deeply regressed and emotionally fragile state, pressing their bodies against him/her to provide an experience of being safely held. I was told that this technique had been pioneered by a female psychoanalyst in

London. Holder (2000) refers to the work of Moser in Germany who also worked with physical contact within a psychoanalytic framework, but suggests that one can take the view that "the kind of body psychotherapy propagated by Moser and others has nothing to do with psychoanalysis" (p. 57). However, many such body psychotherapies have evolved from the work of Wilhelm Reich and are strongly rooted in psychoanalytic theory.

All this shows that the use of touch in psychotherapy is in fact widespread, and there is already an extensive and thoughtful literature on it. Of course, such methods need to be more formally researched, but despite the scientific evidence for the importance of touch, and the probability that it could, when appropriately offered, contribute to meaningful corrective experiences, this is not an area that researchers interested in evidence-based practice have been enthusiastic to venture into.

At the same time, many clients respond to holding that is symbolic—for example, in imagery rescripting, imagining their child-self holding the therapist's hand or sitting on his/her lap. In Kelly's case there was no actual physical contact; however, in sessions 57 and 60, she allowed me to pick up her child-self in the imaginal rescript, and when she saw herself within the circle of safety offering maternal care to Incubator Kelly, she would at times see herself leaning her back against the men in the circle, experiencing their protective support. For other clients, the experience of being held by the safety of the therapy space and the therapist's care is enough to support deep corrective change. What emerges from the literature examined here is the importance of being attuned and responsive to the personal meanings and needs of each individual case.

Because of the recognition of the significance of nurturant touch in parenting, schema therapists are particularly open to its value and are unlikely to be impacted by outdated practices in Freudian psychoanalysis. In practice, the community of schema therapists is likely to be similar to the psychoanalytic therapists polled by Fosshage. In the *Psychoanalytic Inquiry* special issue, Breckenbridge (2000, p. 13) states, "In my practice, nonsexual touching is not uncommon," and describes a thoughtful understanding of the meaning of touch for one client. McLaughlin (2000) also describes a case example where, she concludes,

> In retrospect she had felt that the handholding provided a sense of a mothering acceptance, firm and sure, that "allowed" her to face her mother's abandoning her back then [and giving her the message that she was] untouchably loathesome (p. 78).

In the same issue, Schlesinger and Appelbaum (2000), after reviewing the two sides of this ongoing debate, provide many examples of cases where nurturing touch seemed to be very facilitative, conclude with the recommendation that those running psychoanalytic institutes "consider including in the curriculum such formerly ignored topics as the role of nonerotic physical contact" (p. 140).

This is an appropriate call for trainers in any form of psychotherapy, including schema therapy. Of course, therapists may be accountable to professional bodies that maintain the touch taboo in their code of conduct, but the debate reviewed here shows the need for a mature and flexible approach. Edwards (1981) gave several examples of behaviour therapy interventions that involved the therapist making physical contact with clients and was able to conclude that "for many therapists today, the issue is not so much whether touch is ever allowed, but under what conditions it is appropriate and therapeutic" (p.36). This conclusion is as true today as it was then.

CASE COMPARISONS AND CLINICALLY GROUNDED THEORY

To return to the methodological point made at the beginning of this article, Margolin's (2022) drawing of parallels between the process of Kelly's therapy, and processes within her own cases of Dissociative Identity Disorder, shows the value of describing therapy processes in detail in extended case studies. Clinically grounded theory is best drawn from such detailed observations of many cases. As Dattilio, Edwards, and Fishman (2010, p. 30) argued, detailed narrative accounts provide the basis for

> the inductive building of a system of trustworthy knowledge—sometimes referred to as a *grounded theory*—that can serve to guide practical decision making in such contexts as political, social, and health domains. Such a grounded theory can itself be tested and refined in future studies.

Margolin's (2022) response to my case study of Kelly points to the robustness of the conceptual structure on which schema therapy is based for engaging with and addressing multiplicity due to unmet needs and trauma in childhood, infancy (and before). This structure is increasingly providing a foundation for conceptualizing a wide range of the kinds of phenomena that bring clients to therapy.

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