17. PUTTING THE PIECES TOGETHER: SELF-LEADERSHIP

You are being provided with a book chapter by chapter. I will request you to read the book for me after each chapter. After reading the chapter, 1. shorten the chapter to no less than 300 words and no more than 400 words. 2. Do not change the name, address, or any important nouns in the chapter. 3. Do not translate the original language. 4. Keep the same style as the original chapter, keep it consistent throughout the chapter. Your reply must comply with all four requirements, or it's invalid.
I will provide the chapter now.

I
CHAPTER 17
PUTTING THE PIECES TOGETHER:
SELF-LEADERSHIP
This being human is a guest house. Every morning is a new arrival. A joy, a depression, a meanness, some momentary awareness comes as an unexpected visitor. . . . Welcome and entertain them all. Treat each guest honorably. The dark thought, the shame, the malice, meet them at the door laughing, and invite them in. Be grateful for whoever comes, because each has been sent as a guide from beyond.
—Rumi
A man has as many social selves as there are individuals who recognize him.
—William James, The Principles of Psychology
t was early in my career, and I had been seeing Mary, a shy, lonely, and physically collapsed young woman, for about three months in weekly psychotherapy, dealing with the ravages of her terrible history of early abuse. One day I opened the door to my waiting room and saw her standing there provocatively, dressed in a miniskirt, her hair dyed flaming red, with a cup of coffee in one hand and a snarl on her face. "You must be Dr. van der Kolk," she said. "My name is Jane, and I came to warn you not to believe any the lies that Mary has been telling you. Can I come in and tell you about her?" I was stunned but fortunately kept myself from confronting "Jane" and instead heard her out. Over the course of our session I met not only Jane but also a hurt little girl and an angry male adolescent. That was the beginning of a long and productive treatment.
Mary was my first encounter with dissociative identity disorder (DID), which at that time was called multiple personality disorder. As dramatic as its symptoms are, the internal splitting and emergence of distinct identities experienced in DID represent only the extreme end of the spectrum of mental life. The sense of being inhabited by warring impulses or parts is common to all of us but particularly to traumatized people who had to resort to extreme measures in order to survive. Exploring—even befriending—those parts is an important component of healing.
DESPERATE TIMES REQUIRE DESPERATE MEASURES
We all know what happens when we feel humiliated: We put all our energy into protecting ourselves, developing whatever survival strategies we can. We may repress our feelings; we may get furious and plot revenge. We may

decide to become so powerful and successful that nobody can ever hurt us again. Many behaviors that are classified as psychiatric problems, including some obsessions, compulsions, and panic attacks, as well as most self-destructive behaviors, started out as strategies for self-protection. These adaptations to trauma can so interfere with the capacity to function that health-care providers and patients themselves often believe that full recovery is beyond reach. Viewing these symptoms as permanent disabilities narrows the focus of treatment to finding the proper drug regimen, which can lead to lifelong dependence—as though trauma survivors were like kidney patients on dialysis.1

It is much more productive to see aggression or depression, arrogance or passivity as learned behaviors: Somewhere along the line, the patient came to believe that he or she could survive only if he or she was tough, invisible, or absent, or that it was safer to give up. Like traumatic memories that keep intruding until they are laid to rest, traumatic adaptations continue until the human organism feels safe and integrates all the parts of itself that are stuck in fighting or warding off the trauma.

Every trauma survivor I've met is resilient in his or her own way, and every one of their stories inspires awe at how people cope. Knowing how much energy the sheer act of survival requires keeps me from being surprised at the price they often pay: the absence of a loving relationship with their own bodies, minds, and souls.

Coping takes its toll. For many children it is safer to hate themselves than to risk their relationship with their caregivers by expressing anger or by running away. As a result, abused children are likely to grow up believing that they are fundamentally unlovable; that was the only way their young minds could explain why they were treated so badly. They survive by denying, ignoring, and splitting off large chunks of reality: They forget the abuse; they suppress their rage or despair; they numb their physical sensations. If you were abused as a child, you are likely to have a childlike part living inside you that is frozen in time, still holding fast to this kind of self-loathing and denial. Many adults who survive terrible experiences are caught in the same trap. Pushing away intense feelings can be highly adaptive in the short run. It may help you preserve your dignity and independence; it may help you maintain focus on critical tasks like saving a comrade, taking care of your kids, or rebuilding your house.

The problems come later. After seeing a friend blown up, a soldier may return to civilian life and try to put the experience out of his mind. A protective part of him knows how to be competent at his job and how to get along with colleagues. But he may habitually erupt in rage at his girlfriend or become numb and frozen when the pleasure of surrendering to her touch makes him feel he is losing control. He probably will not be aware that his mind automatically associates passive surrender with the paralysis he felt when his friend was killed. So another protective part steps in to create a diversion: He gets angry and, having no idea what set him off, he thinks he's mad about something his girlfriend did. Of course, if he keeps blowing up at her (and subsequent girlfriends), he will become more and more isolated. But he may never realize that a traumatized part is triggered by passivity and that another part, an angry manager, is stepping in to protect that vulnerable part. Helping these parts to give up their extreme beliefs is how therapy can save people's lives.

As we saw in chapter 13, a central task for recovery from trauma is to learn to live with the memories of the past without being overwhelmed by

them in the present. But most survivors, including those who are functioning well—even brilliantly—in some aspects of their lives, face another, even greater challenge: reconfiguring a brain/mind system that was constructed to cope with the worst. Just as we need to revisit traumatic memories in order to integrate them, we need to revisit the parts of ourselves that developed the defensive habits that helped us to survive.

THE MIND IS A MOSAIC

We all have parts. Right now a part of me feels like taking a nap; another part wants to keep writing. Still feeling injured by an offensive e-mail message, a part of me wants to hit "reply" on a stinging put-down, while a different part wants to shrug it off. Most people who know me have seen my intense, sincere, and irritable parts; some have met the little snarling dog that lives inside me. My children reminisce about going on family vacations with my playful and adventurous parts.

When you walk into the office in the morning and see the storm clouds over your boss's head, you know precisely what is coming. That angry part has a characteristic tone of voice, vocabulary, and body posture—so different from yesterday, when you shared pictures of your kids. Parts are not just feelings but distinct ways of being, with their own beliefs, agendas, and roles in the overall ecology of our lives.

How well we get along with ourselves depends largely on our internal leadership skills—how well we listen to our different parts, make sure they feel taken care of, and keep them from sabotaging one another. Parts often come across as absolutes when in fact they represent only one element in a complex constellation of thoughts, emotions, and sensations. If Margaret shouts, "I hate you!" in the middle of an argument, Joe probably thinks she despises him—and in that moment Margaret might agree. But in fact only a part of her is angry, and that part temporarily obscures her generous and affectionate feelings, which may well return when she sees the devastation on Joe's face.

Every major school of psychology recognizes that people have subpersonalities and gives them different names.2 In 1890 William James wrote: "[I]t must be admitted that . . . the total possible consciousness may be split into parts which coexist, but mutually ignore each other, and share the objects of knowledge between them."3 Carl Jung wrote: "The psyche is a self-regulating system that maintains its equilibrium just as the body does,"4 "The natural state of the human psyche consists in a jostling together of its components and in their contradictory behavior,"5 and "The reconciliation of these opposites is a major problem. Thus, the adversary is none other than 'the other in me.'"6

Modern neuroscience has confirmed this notion of the mind as a kind of society. Michael Gazzaniga, who conducted pioneering split-brain research, concluded that the mind is composed of semiautonomous functioning modules, each of which has a special role.7 In his book The Social Brain (1985) he writes, "But what of the idea that the self is not a unified being, and there may exist within us several realms of consciousness? . . . From our [split-brain] studies the new idea emerges that there are literally several selves, and they do not necessarily 'converse' with each other internally."8 MIT scientist Marvin Minsky, a pioneer of artificial intelligence, declared: "The legend of the single Self can only divert us from the target of that inquiry.9 . . . [I]t can make sense to think there exists, inside your brain, a society of different minds. Like members of a family, the different minds can work together to help each other, each still having

its own mental experiences that the others never know about."[10]

Therapists who are trained to see people as complex human beings with multiple characteristics and potentialities can help them explore their system of inner parts and take care of the wounded facets of themselves. There are several such treatment approaches, including the structural dissociation model developed by my Dutch colleagues Onno van der Hart and Ellert Nijenhuis and Atlanta-based Kathy Steel, that is widely practiced in Europe and Richard Kluft's work in the United States.[11]

Twenty years after working with Mary, I met Richard Schwartz, the developer of internal family systems therapy (IFS). It was through his work that Minsky's "family" metaphor truly came to life for me and offered a systematic way to work with the split-off parts that result from trauma. At the core of IFS is the notion that the mind of each of us is like a family in which the members have different levels of maturity, excitability, wisdom, and pain. The parts form a network or system in which change in any one part will affect all the others.

The IFS model helped me realize that dissociation occurs on a continuum. In trauma the self-system breaks down, and parts of the self become polarized and go to war with one another. Self-loathing coexists (and fights) with grandiosity; loving care with hatred; numbing and passivity with rage and aggression. These extreme parts bear the burden of the trauma.

In IFS a part is considered not just a passing emotional state or customary thought pattern but a distinct mental system with its own history, abilities, needs, and worldview.[12] Trauma injects parts with beliefs and emotions that hijack them out of their naturally valuable state. For example, we all have parts that are childlike and fun. When we are abused, these are the parts that are hurt the most, and they become frozen, carrying the pain, terror, and betrayal of abuse. This burden makes them toxic—parts of ourselves that we need to deny at all costs. Because they are locked away inside, IFS calls them the exiles.

At this point other parts organize to protect the internal family from the exiles. These protectors keep the toxic parts away, but in so doing they take on some of the energy of the abuser. Critical and perfectionistic managers can make sure we never get close to anyone or drive us to be relentlessly productive. Another group of protectors, which IFS calls firefighters, are emergency responders, acting impulsively whenever an experience triggers an exiled emotion.

Each split-off part holds different memories, beliefs, and physical sensations; some hold the shame, others the rage, some the pleasure and excitement, another the intense loneliness or the abject compliance. These are all aspects of the abuse experience. The critical insight is that all these parts have a function: to protect the self from feeling the full terror of annihilation.

Children who act out their pain rather than locking it down are often diagnosed with "oppositional defiant behavior," "attachment disorder," or "conduct disorder." But these labels ignore the fact that rage and withdrawal are only facets of a whole range of desperate attempts at survival. Trying to control a child's behavior while failing to address the underlying issue—the abuse—leads to treatments that are ineffective at best and harmful at worst. As they grow up, their parts do not spontaneously integrate into a coherent personality but continue to lead a relatively autonomous existence.

Parts that are “out” may be entirely unaware of the other parts of the system.13 Most of the men I evaluated with regard to their childhood molestation by Catholic priests took anabolic steroids and spent an inordinate amount of time in the gym pumping iron. These compulsive bodybuilders lived in a masculine culture of sweat, football, and beer, where weakness and fear were carefully concealed. Only after they felt safe with me did I meet the terrified kids inside.

Patients may also dislike the parts that are out: the parts that are angry, destructive, or critical. But IFS offers a framework for understanding them —and, also important, talking about them in a nonpathologizing way. Recognizing that each part is stuck with burdens from the past and respecting its function in the overall system makes it feel less threatening or overwhelming.

As Schwartz states: “If one accepts the basic idea that people have an innate drive toward nurturing their own health, this implies that, when people have chronic problems, something gets in the way of accessing inner resources. Recognizing this, the role of therapists is to collaborate rather than to teach, confront, or fill holes in your psyche.”14 The first step in this collaboration is to assure the internal system that all parts are welcome and that all of them—even those that are suicidal or destructive—were formed in an attempt to protect the self-system, no matter how much they now seem to threaten it.

SELF-LEADERSHIP

IFS recognizes that the cultivation of mindful self-leadership is the foundation for healing from trauma. Mindfulness not only makes it possible to survey our internal landscape with compassion and curiosity but can also actively steer us in the right direction for self-care. All systems—families, organizations, or nations—can operate effectively only if they have clearly defined and competent leadership. The internal family is no different: All facets of our selves need to be attended to. The internal leader must wisely distribute the available resources and supply a vision for the whole that takes all the parts into account.

As Richard Schwartz explains:

> The internal system of an abuse victim differs from the non-abuse system with regard to the consistent absence of effective leadership, the extreme rules under which the parts function, and the absence of any consistent balance or harmony. Typically, the parts operate around outdated assumptions and beliefs derived from the childhood abuse, believing, for example, that it is still extremely dangerous to reveal secrets about childhood experiences which were endured.15

What happens when the self is no longer in charge? IFS calls this “blending”: a condition in which the Self identifies with a part, as in “I want to kill myself” or “I hate you.” Notice the difference from “A part of me wishes that I were dead” or “A part of me gets triggered when you do that and makes me want to kill you.”

Schwartz makes two assertions that extend the concept of mindfulness into the realm of active leadership. The first is that this Self does not need to be cultivated or developed. Beneath the surface of the protective parts of trauma survivors there exists an undamaged essence, a Self that is confident, curious, and calm, a Self that has been sheltered from destruction by the various protectors that have emerged in their efforts to ensure survival. Once those protectors trust that it is safe to separate, the Self will

spontaneously emerge, and the parts can be enlisted in the healing process. The second assumption is that, rather than being a passive observer, this mindful Self can help reorganize the inner system and communicate with the parts in ways that help those parts trust that there is someone inside who can handle things. Again neuroscience research shows that this is not just a metaphor. Mindfulness increases activation of the medial prefrontal cortex and decreases activation of structures like the amygdala that trigger our emotional responses. This increases our control over the emotional brain.

Even more than encouraging a relationship between a therapist and a helpless patient, IFS focuses on cultivating an inner relationship between the Self and the various protective parts. In this model of treatment the Self doesn't only witness or passively observe, as in some meditation traditions; it has an active leadership role. The Self is like an orchestra conductor who helps all the parts to function harmoniously as a symphony rather than a cacophony.

GETTING TO KNOW THE INTERNAL LANDSCAPE

The task of the therapist is to help patients separate this confusing blend into separate entities, so that they are able to say: "This part of me is like a little child, and that part of me is more mature but feels like a victim." They might not like many of these parts, but identifying them makes them less intimidating or overwhelming. The next step is to encourage patients to simply ask each protective part as it emerges to "stand back" temporarily so that we can see what it is protecting. When this is done again and again, the parts begin to unblend from the Self and make space for mindful self-observation. Patients learn to put their fear, rage, or disgust on hold and open up into states of curiosity and self-reflection. From the stable perspective of Self they can begin constructive inner dialogues with their parts.

Patients are asked to identify the part involved in the current problem, like feeling worthless, abandoned, or obsessed with vengeful thoughts. As they ask themselves, "What inside me feels that way?" an image may come to mind.16 Maybe the depressed part looks like an abandoned child, or an aging man, or an overwhelmed nurse taking care of the wounded; a vengeful part might appear as a combat marine or a member of a street gang.

Next the therapist asks, "How do you feel toward that (sad, vengeful, terrified) part of you?" This sets the stage for mindful self-observation by separating the "you" from the part in question. If the patient has an extreme response like "I hate it," the therapist knows that there is another protective part blended with Self. He or she might then ask, "See if the part that hates it would step back." Then the protective part is often thanked for its vigilance and assured that it can return anytime that it is needed. If the protective part is willing, the follow-up question is: "How do you feel toward the (previously rejected) part now?" The patient is likely to say something like "I wonder why it is so (sad, vengeful etc.)." This sets the stage for getting to know the part better—for example, by inquiring how old it is and how it came to feel the way it does.

Once a patient manifests a critical mass of Self, this kind of dialogue begins to take place spontaneously. At this point it's important for the therapist to step aside and just keep an eye out for other parts that might interfere, or make occasional empathic comments, or ask questions like "What do you say to the part about that?" or "Where do you want to go

now?" or "What feels like the right next step?" as well as the ubiquitous Self-detecting question, "How do you feel toward the part now?"

A LIFE IN PARTS

Joan came to see me to help her manage her uncontrollable temper tantrums and to deal with her guilt about her numerous affairs, most recently with her tennis coach. As she put it in our first session: "I go from being a kick-ass professional woman to a whimpering child, to a furious bitch, to a pitiless eating machine in the course of ten minutes. I have no idea which of these I really am."

By this point in the session, Joan had already critiqued the prints on my wall, my rickety furniture, and my messy desk. Offense was her best defense. She was preparing to get hurt again—I'd probably let her down, as so many people had before. She knew that for therapy to work, she'd have to make herself vulnerable, so she had to find out if I could tolerate her anger, fear, and sorrow. I realized that the only way to counter her defensiveness was by showing a high level of interest in the details of her life, demonstrating unwavering support for the risk she took in talking with me, and accepting the parts she was most ashamed of.

I asked Joan if she had noticed the part of herself that was critical. She acknowledged that she had, and I asked her how she felt toward that critic. This key question allowed her to begin to separate from that part and to access her Self. Joan responded that she hated the critic, because it reminded her of her mother. When I asked her what that critical part might be protecting, her anger subsided, and she became more curious and thoughtful: "I wonder why she finds it necessary to call me some of the same names that my mother used to call me, and worse." She talked about how scared she had been of her mom growing up and how she felt that she never could do anything right. The critic was obviously a manager: Not only was it protecting Joan from me, but it was trying to preempt her mother's criticism.

Over the next few weeks Joan told me that she had been sexually molested by her mother's boyfriend, probably around the time she was in the first or second grade. She thought she'd been "ruined" for intimate relationships. While she was demanding and critical of her husband, for whom she lacked any sexual desire, she was passionate and reckless in her love affairs. But the affairs always ended in a similar way: In the middle of a lovemaking session, she would suddenly become terrified and curl up into a ball, whimpering like a little girl. These scenes left her confused and disgusted, and afterward she could not bear to have anything more to do with her lover.

Like Marilyn in chapter 8, Joan told me that she had learned to make herself disappear when she was being molested, floating above the scene as if it were happening to some other girl. Pushing the molestation out of her mind had enabled Joan to have a normal school life of sleepovers, girlfriends, and team sports. The trouble began in adolescence, when she developed her pattern of frigid contempt for boys who treated her well and having casual sex that left her humiliated and ashamed. She told me that bulimia for her was what orgasms must be for other people, and having sex with her husband for her was what vomiting must be for others. While specific memories of her abuse were split off (dissociated), she unwittingly kept reenacting it.

I did not try to explain to her why she felt so angry, guilty, or shut down—she already thought of herself as damaged goods. In therapy, as in

memory processing, pendulation—the gradual approach that I discussed in chapter 13—is central. For Joan to be able to deal with her misery and hurt, we would have to recruit her own strength and self-love, enabling her to heal herself.

This meant focusing on her many inner resources and reminding myself that I could not provide her with the love and caring she had missed as a child. If, as a therapist, teacher, or mentor, you try to fill the holes of early deprivation, you come up against the fact that you are the wrong person, at the wrong time, in the wrong place. The therapy would focus on Joan's relationship with her parts rather than with me.

MEETING THE MANAGERS

As Joan's treatment progressed, we identified many different parts that were in charge at different times: an aggressive childlike part that threw tantrums, a promiscuous adolescent part, a suicidal part, an obsessive manager, a prissy moralist, and so on. As usual, we met the managers first. Their job was to prevent humiliation and abandonment and to keep her organized and safe. Some managers may be aggressive, like Joan's critic, while others are perfectionistic or reserved, careful not to draw too much attention to themselves. They may tell us to turn a blind eye to what is going on and keep us passive to avoid risk. Internal managers also control how much access we have to emotions, so that the self-system doesn't get overwhelmed.

It requires an enormous amount of energy to keep the system under control. A single flirtatious comment may trigger several parts simultaneously: one that becomes intensely sexually aroused, another filled with self-loathing, a third that tries to calm things down by self-cutting. Other managers create obsessions and distractions or deny reality altogether. But each part should be approached as an internal protector who maintains an important defensive position. Managers carry huge burdens of responsibility and usually are in over their heads.

Some managers are extremely competent. Many of my patients hold responsible positions, do outstanding professional jobs, and can be superbly attentive parents. Joan's critical manager undoubtedly contributed to her success as an ophthalmologist. I have had numerous patients who were highly skilled teachers or nurses. While their colleagues may have experienced them as a bit distant or reserved, they would probably have been astonished to discover that their exemplary coworkers engaged in self-mutilation, eating disorders, or bizarre sexual practices.

Gradually Joan started to realize that it is normal to simultaneously experience conflicting feelings or thoughts, which gave her more confidence to face the task ahead. Instead of believing that hate consumed her entire being, she learned that only a part of her felt paralyzed by it. However, after a negative evaluation at work Joan went into a tailspin, berating herself for not protecting herself, then feeling clingy, weak, and powerless. When I asked her to see where that powerless part was located in her body and how she felt toward it, she resisted. She told me she couldn't stand that whiny, incompetent girl who made her feel embarrassed and contemptuous of herself. I suspected that this part held much of the memory of her abuse, and I decided not to pressure her at this point. She left my office withdrawn and upset.

The next day she raided the refrigerator and then spent hours vomiting up her food. When she returned to my office, she told me she wanted to kill herself and was surprised that I seemed genuinely curious and

nonjudgmental and that I did not condemn her for either her bulimia or her suicidality. When I asked her what parts were involved, the critic came back and blurted out, “She is disgusting.” When she asked that part to step back, the next part said: “Nobody will ever love me,” followed again by the critic, who told me that the best way to help her would be to ignore all that noise and to increase her medications.

Clearly, in their desire to protect her injured parts, these managers were unintentionally doing her harm. So I kept asking them what they thought would happen if they stepped back. Joan answered: “People will hate me” and “I will be all alone and out in the street.” This was followed by a memory: Her mother had told her that if she disobeyed, she would be put up for adoption and never see her sisters or her dog again. When I asked her how she felt about that scared girl inside, she cried and said that she felt bad for her. Now her Self was back, and I was confident that we had calmed the system down, but this session turned out to be too much too soon.

PUTTING OUT THE FLAMES

The following week Joan missed her appointment. We had triggered her exiles, and her firefighters went on a rampage. As she told me later, the evening after we talked about her terror of being put into foster care, she felt as if she were going to blast out of herself. She went to a bar and picked up a guy. Coming home late, drunk, and disheveled, she refused to talk to her husband and fell asleep in the den. The next morning she acted as if nothing had happened.

Firefighters will do anything to make emotional pain go away. Aside from sharing the task of keeping the exiles locked up, they are the opposite of managers: Managers are all about staying in control, while firefighters will destroy the house in order to extinguish the fire. The struggle between uptight managers and out-of-control firefighters will continue until the exiles, which carry the burden of the trauma, are allowed to come home and be cared for.

Anyone who deals with survivors will encounter those firefighters. I’ve met firefighters who shop, drink, play computer games addictively, have impulsive affairs, or exercise compulsively. A sordid encounter can blunt the abused child’s horror and shame, if only for a couple of hours.

It is critical to remember that, at their core, firefighters are also desperately trying to protect the system. Unlike managers, who are usually superficially cooperative during therapy, firefighters don’t hold back: They hurl insults and storm out of the room. Firefighters are frantic, and if you ask them what would happen if they stopped doing their job, you discover that they believe the exiled feelings would crash the entire self-system. They are also oblivious to the idea that there are better ways to guarantee physical and emotional safety, and even if behaviors like bingeing or cutting stop, firefighters often find other methods of self-harm. These cycles will come to an end only when the Self is able to take charge and the system feels safe.

THE BURDEN OF TOXICITY

Exiles are the toxic waste dump of the system. Because they hold the memories, sensations, beliefs, and emotions associated with trauma, it is hazardous to release them. They contain the “Oh, my God, I’m done for” experience—the essence of inescapable shock—and with it, terror, collapse, and accommodation. Exiles may reveal themselves in the form of crushing physical sensations or extreme numbing, and they offend both the reasonableness of the managers and the bravado of the firefighters.

Like most incest survivors, Joan hated her exiles, particularly the little girl who had responded to her abuser's sexual demands and the terrified child who whimpered alone in her bed. When exiles overwhelm managers, they take us over—we are nothing but that rejected, weak, unloved, and abandoned child. The Self becomes "blended" with the exiles, and every possible alternative for our life is eclipsed. Then, as Schwartz points out, "We see ourselves, and the world, through their eyes and believe it is 'the' world. In this state it won't occur to us that we have been hijacked."17 Keeping the exiles locked up, however, stamps out not only memories and emotions but also the parts that hold them—the parts that were hurt the most by the trauma. In Schwartz's words: "Usually those are your most sensitive, creative, intimacy-loving, lively, playful and innocent parts. By exiling them when they get hurt, they suffer a double whammy—the insult of your rejection is added to their original injury."18 As Joan discovered, keeping the exiles hidden and despised was condemning her to a life without intimacy or genuine joy.

UNLOCKING THE PAST

Several months into Joan's treatment we again accessed the exiled girl who carried the humiliation, confusion, and shame of Joan's molestation. By then she had come to trust me enough and had developed enough sense of Self to be able to tolerate observing herself as a child, with all her long-buried feelings of terror, excitement, surrender, and complicity. She did not say very much during this process, and my main job was to keep her in a state of calm self-observation. She often had the impulse to pull away in disgust and horror, leaving this unacceptable child alone in her misery. At these points I asked her protectors to step back so that she could keep listening to what her little girl wanted her to know.

Finally, with my encouragement, she was able to rush into the scene and take the girl away with her to a safe place. She firmly told her abuser that she would never let him get close to her again. Instead of denying the child, she played an active role in liberating her. As in EMDR the resolution of the trauma was the result of her ability to access her imagination and rework the scenes in which she had become frozen so long ago. Helpless passivity was replaced by determined Self-led action.

Once Joan started to own her impulses and behaviors, she recognized the emptiness of her relationship with her husband, Brian, and began to insist on change. I invited her to ask Brian to meet with us, and she was present for eight sessions before he began to see me individually.

Schwartz observes that IFS can help family members "mentor" each other as they learn to observe how one person's parts interact with another's. I witnessed this firsthand with Joan and Brian. Brian was initially quite proud of having put up with Joan's behavior for so long; feeling that she really needed him had kept him from even considering divorce. But now that she wanted more intimacy, he felt pressured and inadequate—revealing a panicked part that blanked out and put up a wall against feeling. Gradually Brian began to talk about growing up in an alcoholic family where behaviors like Joan's were common and largely ignored, punctuated by his father's stays in detox centers and his mother's long hospitalizations for depression and suicide attempts. When I asked his panicked part what would happen if it allowed Brian to feel anything, he revealed his fear of being overwhelmed by pain—the pain of his childhood added to the pain of his relationship with Joan.

Over the next few weeks other parts emerged. First came a protector

that was frightened of women and determined never to let Brian become vulnerable to their manipulations. Then we discovered a strong caretaker part that had looked after his mother and his younger siblings. This part gave Brian a feeling of self-worth and purpose and a way of dealing with his own terror. Finally, Brian was ready to meet his exile, the scared, essentially motherless child who'd had no one to care for him.

This is a very short version of a long exploration, which involved many diversions, as when Joan's critic reemerged from time to time. But from the beginning IFS helped Joan and Brian hear themselves and each other from the perspective of an objective, curious, and compassionate Self. They were no longer locked in the past, and a whole range of new possibilities opened up for them.

THE POWER OF SELF-COMPASSION: IFS IN THE TREATMENT OF RHEUMATOID ARTHRITIS

Nancy Shadick is a rheumatologist at Boston's Brigham and Women's Hospital who combines medical research on rheumatoid arthritis (RA) with a strong interest in her patients' personal experience of their illness. When she discovered IFS at a workshop with Richard Schwartz, she decided to incorporate the therapy into a study of psychosocial intervention with RA patients.

RA is an autoimmune disease that causes inflammatory disorders throughout the body, causing chronic pain and disability. Medication can delay its progress and relieve some of the pain, but there is no cure, and living with RA can lead to depression, anxiety, isolation, and overall impaired quality of life. I followed this study with particular interest because of the link I'd observed between trauma and autoimmune disease.

Working with senior IFS therapist Nancy Sowell, Dr. Shadick created a nine-month randomized study in which one group of RA patients would receive both group and individual instruction in IFS while a control group received regular mailings and phone calls regarding disease symptoms and management. Both groups continued with their regular medications, and they were assessed periodically by rheumatologists who were not informed which group they belonged to.

The goal of the IFS group was to teach patients how to accept and understand their inevitable fear, hopelessness, and anger and to treat those feelings as members of their own "internal family." They would learn the inner dialogue skills that would enable them to recognize their pain, identify the accompanying thoughts and emotions, and then approach these internal states with interest and compassion.

A basic problem emerged early. Like so many trauma survivors, the RA patients were alexithymic. As Nancy Sowell later told me, they never complained about their pain or disability unless they were totally overwhelmed. Asked how they were feeling, they almost always replied, "I'm fine." Their stoic parts clearly helped them cope, but these managers also kept them in a state of denial. Some shut out their bodily sensations and emotions to the extent that they could not collaborate effectively with their doctors.

To get things moving, the leaders introduced the IFS parts dramatically, rearranging furniture and props to represent managers, exiles, and firefighters. Over the course of several weeks, group members began to talk about the managers who told them to "grin and bear it" because no one wanted to hear about their pain anyway. Then, as they asked the stoic parts to step back, they started to acknowledge the angry part that wanted to yell

and wreak havoc, the part that wanted stay in bed all the time, and the exile who felt worthless because she wasn't allowed to talk. It emerged that, as children, nearly all of them were supposed to be seen and not heard—safety meant keeping their needs under wraps.

Individual IFS therapy helped patients apply the language of parts to daily issues. For example, one woman felt trapped by conflicts at her job, where a manager part insisted the only way out was to overwork until her RA flared up. With the therapist's help she realized that she could care for her needs without making herself sick.

The two groups, IFS and controls, were evaluated three times during the nine-month study period and then again one year later. At the end of nine months, the IFS group showed measurable improvements in self-assessed joint pain, physical function, self-compassion, and overall pain relative to the education group. They also showed significant improvements in depression and self-efficacy. The IFS group's gains in pain perception and depressive symptoms were sustained one year later, although objective medical tests could no longer detect measurable improvements in pain or function. In other words, what had changed most was the patients' ability to live with their disease. In their conclusions, Shadick and Sowell emphasized IFS's focus on self-compassion as a key factor.

This was not the first study to show that psychological interventions can help RA patients. Cognitive behavioral therapies and mindfulness-based practices have also been shown to have a positive impact on pain, joint inflammation, physical disability, and depression.19 However, none of these studies has asked a crucial question: Are increased psychological safety and comfort reflected in a better-functioning immune system?

LIBERATING THE EXILED CHILD

Peter ran an oncology service at a prestigious academic medical center that was consistently rated as one of the best in the country. As he sat in my office, in perfect physical shape because of his regular squash practice, his confidence had crossed the line into arrogance. This man certainly did not seem to suffer from PTSD. He told me he just wanted to know how he could help his wife to be less "touchy." She had threatened to leave him unless he did something about what she termed his callous behavior. Peter assured me that her perception was warped, because he obviously had no problem being empathic with sick people.

He loved talking about his work, proud of the fact that residents and fellows competed fiercely to be on his service and also of scuttlebutt he'd heard about his staff being terrified of him. He described himself as brutally honest, a real scientist, someone who just looked at the facts and—with a meaningful glance in my direction—did not suffer fools gladly. He had high standards, but no higher than he had for himself, and he assured me that he didn't need anybody's love, just their respect.

Peter also told me that his psychiatry rotation in med school had convinced him that psychiatrists still practiced witchcraft, and his one stint in couples' therapy had further confirmed that opinion. He expressed contempt for people who blamed their parents or society for their problems. Even though he had had his own share of misery as a child, he was determined never to think of himself as a victim.

While Peter's toughness and his love for precision appealed to me, I could not help but wonder if we would discover something I'd seen all too often: that internal managers who are obsessed with power are usually created as a bulwark against feeling helpless.

When I asked him about his family, Peter told me that his father ran a manufacturing business. He was a Holocaust survivor who could be brutal and exacting, but he also had a tender and sentimental side that had kept Peter connected with him and that had inspired Peter to become a physician. As he told me about his mother, he realized for the first time that she had substituted rigorous housekeeping for genuine care, but Peter denied that this bothered him. He went to school and got straight As. He had vowed to build a life free of rejection and humiliation, but, ironically, he lived with death and rejection every day—death on the oncology ward and the constant struggle to get his research funded and published.

Peter's wife joined us for the next meeting. She described how he criticized her incessantly—her taste in clothes, her child-rearing practices, her reading habits, her intelligence, her friends. He was rarely at home and never emotionally available. Because he had so many important obligations, and because he was so explosive, his family always tiptoed around him. She was determined to leave him and start a new life unless he made some radical changes. At that point, for the first time, I saw Peter become obviously distressed. He assured me and his wife that he wanted to work things out.

At our next session I asked him to let his body relax, close his eyes, focus his attention inside, and ask that critical part—the one his wife had identified—what it was afraid would happen if he stopped his ruthless judging. After about thirty seconds he said he felt stupid talking to himself. He didn't want to try some new age gimmick—he'd come to me looking for "empirically verified therapy." I assured him that, like him, I was at the forefront of empirically based therapies and that this was one of them. He was silent for perhaps a minute before he whispered: "I would get hurt." I urged him to ask the critic what that meant. Still with his eyes closed, Peter replied: "If you criticize others, they don't dare to hurt you." Then: "If you are perfect, nobody can criticize you." I asked him to thank his critic for protecting him against hurt and humiliation, and as he became silent again, I could see his shoulders relax and his breathing become slower and deeper. He next told me that he was aware that his pomposity was affecting his relationships with his colleagues and students; he felt lonely and despised during staff meetings and uncomfortable at hospital parties. When I asked him if he wanted to change the way that angry part threatened people, he replied that he did. I then asked him where it was located in his body, and he found it in the middle of his chest. Keeping his focus inside, I asked him how he felt toward it. He said it made him scared.

Next I asked him to stay focused on it and see how he felt toward it now. He said he was curious to know more about it. I asked him how old it was. He said about seven. I asked him to have his critic show him what he protected. After a lengthy silence, still with his eyes closed, he told me that he was witnessing a scene from his childhood. His father was beating a little boy, him, and he was standing to one side thinking how stupid that kid was to provoke his dad. When I asked him how he felt about the boy who was getting hurt, he told me that he despised him. He was a weakling and a whiner; after showing even the least bit of defiance to his dad's high-handed ways, he inevitably capitulated and whimpered that he would be a good little boy. He had no guts, no fire in his belly. I asked the critic if he would be willing to step aside so we could see what was going on with that boy. In response the critic appeared in full force and called him names like "wimp" and "sissy." I asked Peter again if the critic would be willing to step

aside and give the boy a chance to speak. He shut down completely and left the session saying that he was unlikely ever to set foot in my office again. But the following week he was back: As she had threatened, his wife had gone to a lawyer and filed for divorce. He was devastated and no longer looked anything like the perfectly put-together doctor whom I'd come to know and, in many ways, dread. Faced with the loss of his family, he became unhinged and felt comforted by the idea that if things got too bad he could take his life in his own hands.

We went inside again and identified the part that was terrified of abandonment. Once he was in his mindful Self-state, I urged him to ask that terrified boy to show him the burdens he was carrying. Again, his first reaction was disgust at the boy's weakness, but after I asked him to get that part to step back, he saw an image of himself as a young boy in his parents' house, alone in his room, screaming in terror. Peter watched this scene for several minutes, weeping silently through much of it. I asked him if the boy had told him everything he wanted him to know. No, there were other scenes, like running to embrace his father at the door and getting slapped for having disobeyed his mother.

From time to time he would interrupt the process by explaining why his parents couldn't have done any better than they had, their being Holocaust survivors and all that implied. Again I suggested he find the protective parts that were interrupting the witnessing of the boy's pain and request that they move temporarily to another room. And each time he was able to return to his grief.

I asked Peter to tell the boy that he now understood how bad the experience had been. He sat in a long, sad silence. Then I asked him to show the boy that he cared about him. After some coaxing he put his arms around the boy. I was surprised that this seemingly harsh and callous man knew exactly how to take care of him.