Making Room for *And*: The integration of "Me" and "Us"

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Author's Note: *This article is a portion of a book that I have been writing on and off for some time now. The book is about my relational journey through the world including stories from my own development, parenting my daughter, my years of clinical work, my work on death penalty cases, and the larger sociopolitical context and community. This article explores one portion of the book: the relational process and impacts of the damaging choice between "me" and "us" that is imposed on many children growing up with damaged or ill-equipped caretakers where they are actively traumatized and denied the attachment experiences they need for healthy, integrative development. Over the years, the licensed mental health practitioners who have been in my consultation groups have learned to use, embody, and struggle with "And" instead of "Or." My patients and I have worked together in many modalities to heal the lack of an "and" in their intra- and interpersonal worlds and make "seeing the in-between" possible. I have collected many vignettes and descriptions of the presence and impact of the forced choice between these critical aspects of development, and of some of the healing and integration that I have been honored to witness and be a part of. This article is a small sampling of the clinical case examples, theory, and science that will be explored within the book.*

A Relational Frame for Development and Healing

I have always practiced psychotherapy relationally and recall my excitement, many years ago, listening to Judith Jordan's presentation at an APA convention. While representing the clinical theory and practice of the work developed at the Stone Center, now the Wellesley Centers For Women and the Jean Baker Miller Training Institute, she helped provide illustrative words for the way I had been interacting with my patients for years. Clearly, many therapists share this sense about the essential nature of attending to relationship, as seen in the wide interest in Interpersonal Neurobiology (IPNB) (e.g., Cozolino, 2006; Schore, 2003; Siegel, 2010, 2012) and in our field's return to our knowledge base in Attachment Theory (e.g., Ainsworth, 1993; Main et al., 2008) and practice (e.g, Hughes, 2007) as well as the relational, experiential basis of our development, (e.g., Sroufe et al., 2005). All of these works have resonated thoroughly with me and with my experience as a clinician. During my lectures and teaching, I introduce human development and the experiential shaping of the genetically programmed maturation of the nervous system with this simple statement: "We are formed in relationship, damaged in relationship, and healed in relationship." Some of my talks have been entitled "When Nurture becomes Nature" to emphasize the most formative portion of early experience: the caretaking relationships and their epigenetic effects (the experiential impact on how or if our genes are expressed) on our development and functioning. Even when I testify in capital cases, I educate the courtroom on neuroplasticity, epigenetics, and integration as a state of health. This is why the research findings that the nature of the therapeutic relationship is such a crucial variable in therapy outcomes makes intuitive sense to me—how could it not be so?

Based in this knowledge, we think of therapeutic relationships in a positive light, as corrective sources of repair and healing; and in the long run I strongly believe that they are or can be just that. At the same time, we need to be very sensitive to the fact that connection and relationship have also been quite *harmful* to some people and establishing a reparative relationship during therapy may be more complex than we anticipate. Relatedly, I have tended to think of the development of mirror neurons (Iacoboni, 2009) and the social circuitry connected to them as emanating from and serving a "positive" source and purpose. Yet we can wonder what might happen in mirror neuron development for the people who develop an amygdala-based sensitized alert system, based in their need to be hyper-vigilant about the other? We know the sensitized alert system is an "adaptive" brain development response to an environment where the child must read and anticipate their caretakers' every move and intention, in an attempt to survive or stay safe in abusive, neglectful, and seriously mentally ill families. When one has to focus on the other(s) so exclusively that there can be no "I," is it possible that the ways the mirror neurons and the related social brain circuitry associated

with empathy, mindsight, (Siegel, 2010) and social functioning develop, are primarily as mirrors of others' states, without the development of a differentiated sense of self, or of the next level, that of self-in-relatedness?

In GAINS Advisory Board Member Diane Ackerman's article "The Brain on Love," published in the New York Times (3/24/13), she passionately described the "crucible" of positive attachment and the "we" or "us" that is at the center of it. In addition to the consistent praise from readers, online responses also included comments and questions about those of us who are not provided with this experience of a safe "us" to hold our emerging selves. People inquired "what about me?" They were naming the experience of trying to survive and function without the presence of a safe or containing attachment relationship and instead being forced into the impossible and devastating choice between connection and a self. Let's focus in on this choice, and its clinical or relational manifestations.

The Impossible Choice Between Me and Us

During the consultation group I run, we share a rather continuous joke about "Julie's 'And'" and everyone in the group tries to replace "But" and "Or" with "And" most of the time. This is something that naturally develops in my work with patients as well. Do we all do this just as a turn of phrase or as an obsessive-compulsive correction of grammar? No, this is not a linguistic exercise at all. Its meaning rests in the essential experiential and developmental security found in transcending "either/ors" into "both/ands." It is an acknowledgement of what I have found to be at the core of the damage and ensuing relational difficulties that result from the devastating choices people who grow up in attachment disordered, trauma-based, or narcissistic families must make. Whatever label is used to describe such families, at their core is the wounding process of formative trauma or attachment-disordered development, and the subsequent wiring and functioning related to having to choose between a self and connection to others.

In these family contexts, to have an "us" one cannot have an "I" or "me"; and to claim an "I" means a rupture of any "us" they may have had. These individuals were repetitively forced into a choice between themselves and relationship: me or us but not me AND us. Thus, the very essence of healthy attachment, where children have safe room for themselves and their experience *within* the context of formative relationships, is denied. To be part of the "us" necessary for our very survival, these children must disappear or silence their own selves and experiences. To express their feelings or to need acknowledgement is to risk abandonment, assault, or being blamed for the suffering of parents who shut down or flood in reaction to significant emotion or need. Either way, expression of self results in loss of connection to the caretaker(s). Thus to survive—as connection is in fact our life line—one must deny one's own needs and disappear oneself, or become annihilated by damaged and abusive others. With this insurmountable dichotomy, relationships come to represent the source of actual or threatened loss and abandonment rather than the connection one needs to develop a healthy integrated self. As a result, people end up fragmented or empty inside (dissociated or with "no there, there") and their real-time relationships are constricted by the same choices and lack of AND as in their formative years.

This forced choice between "me" and "us" has an annihilating effect in either direction. Although they can be necessary to ensure one's psychosocial survival (not health) at the time, neither of these "choices" actually work over time. That is, these situations cannot lead to the integrated selves or states that are so necessary for the ongoing neuropsychiatric health and regulatory or social functioning that we expect or hope for from adults. To develop coherency and a flexible, adaptive self, who can tolerate and respond to stress, and accommodate and create intimacy and emotion, it is necessary to be able to safely be part of an "us." Yet far too often children are forced to make the choices between themselves and that connection, living lives where, in the words of Bowlby (1969), it is not safe or even possible to know what you know and to be part of your attachment relationships at the same time. The results of these forced choices are fracturing, discontinuity, disintegration, emptiness, dissociation, dysregulation, reactivity, and rage. Shame and its toxic impacts predominate their internal landscapes. These people who lived with these impossible choices do not enjoy a state of integration on most or all levels. Their limbic systems and executive systems (frontal lobes) are not in working connection, nor do they experience temporal, interpersonal, memory, or transpirational integration. They are reactive rather than responsive, and they have no sense of themselves in time or space let alone in relationship to others or a greater whole. They have no sense of an embodied self and are unable to picture or describe the experience in their chest/heart or gut despite the activity of the neural nets present there. Thus the "bottom up" interventions that we employ regularly in IPNB work may be experienced as foreign or unusable for quite some time. Descriptions of their internal lives include "splitting." (The DBT language of dialectics and the inability to hold both or multiple aspects of an experience is a therapeutic model of this.) Through this forced "choice" and it's sequelae, people become labeled and diagnosed in pejorative ways such as "borderline" or an equally negative moniker, and can end up treating themselves and others in damaging or even horrific ways. In fact, death penalty cases are replete with individuals who are descendants of multiple years of attachment breaches and abuse who have no stress tolerance or regulatory functioning and become reactive, defensive, and destructive in the face of others who they implicitly experience as a threat. (e.g. Sunderland, 2006).

Relational Therapy with Me or Us

This "me OR us" also comes into the therapy relationship. These patients literally cannot conceive of or imagine an experience where they could have a connection to someone else and still have room for themselves, simultaneously. Given the overlap of the perceptual and motor tracks in the nervous system, the behaviors associated with a safe or connected relationship are not readily available to them either. With these individuals, our offer of such an attachment or relationship may not result in the responses that we as therapists are anticipating.

As clinicians, we need to be aware of our own feelings (or even demands), of needing and wanting our patients to respond well to our therapy relationship with them, and to show healing as a result. Of critical importance is that the therapy relationship provide something different than the formative and repetitive experiences that laid down the wiring (or "superhighways" of neural connections) that govern our patients' responses. For those people who were exposed to early formative trauma, the idea that short-term treatment can overcome years of wiring, quickly creating enough safety for them to find meanings and words to make explicit the implicit narratives and responses that have governed their functioning, and to then create new meanings and behavioral changes, is often an unrealistic expectation. Yet our patients often hold this expectation or hope, that they should be healed quickly and thoroughly. But they hold it side by side with the belief that no person or relationship can provide a safe (different) connection they can trust. So in this context, the therapist requesting or requiring connection may not feel safe to the patient at all, and this can lead to damaging impacts, or at least to a breach or rupture in the relationship/attachment, especially if relatedness is pushed or expected in a way that is not contingent with our patient's state or internal experience.

For example, once I (way too early) wondered with a patient what it might be like to consider me or the therapy relationship as quite different than the judgmental and punitive relationships he had grown up with, when he suddenly began to cry out in the voice of a very young person, crying that his arms hurt, and rubbing his chest. He was showing me that relationship was threatening and hurtful for him and that my offering of it was not experienced as safe or healing but as assaultive instead. It was like pushing him towards fear and pain, and his body reacted. Many patients may be experiencing this without showing it so directly.

This particular patient was also showing me the level of disintegration and dissociation that had developed as a result of his traumatic past, his internal disorganization as an adult now fitting the diagnosis of Dissociative Identity Disorder. I usually place a relational frame around the therapy with people working through traumatic events and relationships. I tell patients that they do not have to or even get to "go there alone." I explain that they have been alone in these experiences long enough, and to make sure that this relationship is different we need to make sure that I "go with" them in these experiences. We slow things down and use mindful breathing and awareness as well as a host of additional somatic and relational strategies to facilitate this happening. In his healing, the awareness of his dissociative capacity required that we back up into developing somatically based ways that he could soothe and calm himself, before we proceeded. He felt empowered by finding that placing his right hand on his chest/heart and finding his feet on the ground could calm his nervous system enough to allow increasing amounts of his experience to be expressed and explored within the therapeutic relationship. In the context of "us," he was learning to notice and comfort a "me." Similarly, encouraging him to act on his own behalf (something that early formative trauma experiences routinely prohibit) by inviting him to get up and move in the room when the need arose, while maintaining a connection between us through narrating the experience as it was unfolding, also created the experience of himself and us rather than one or the other. That is, the ability to move rather than feel trapped or frozen in relationship was a new experience, and led to an experiential knowing of the possibility of "me and us" without a punitive or rejecting outcome.

For this man, these interventions, coupled with education about and narration of what had happened to him, came as a relief. But he still did not trust "AND" inside himself. He still was scared that a goal of integration of his dissociated parts meant the *annihilation* of the very parts of him that (who) had allowed him to survive. In this case, integration or "and" was still a threat, not the promise of health. We respected this in-between place. We found ways of having his core adult self apply and use many of the strengths, needs, and interests, in his adult/present life, so that those parts were honored and kept alive. Currently, he is struggling with living in the "in-between" and coping with both life's negatives as well as positives from within a single self. This "And" is a difficult one to tolerate as he believed that healing himself would lead to a perfect and enlightened place, not a place where people are mean or self-serving as well as caring. We are also continuing to develop an "And" within the therapy room by making room for and narrating his feelings and needs directly, within the relationship. Of course we do this while acknowledging his ever-present fear that this will result in a rupture of our relationship or in outright abandonment.

I have found that individuals with these histories may frequently end up experiencing rejecting and frustrated responses from their therapists as this dynamic that predominates their internal and relational states and responses expresses in the therapeutic relationship. An example of this happened with a patient of mine, who had worked extremely hard at allowing herself to know and work through a severe abuse history at the hands

of her mother and concomitant abandonment and neglect with her father. As a child, she had never had any safe room for herself or her feelings and had no words for her own experience. After extended time in relational therapy, she had arrived at the point where she was able to talk about what she needed and wanted in relationship and was progressing with healthy individuation and considering separating from her girlfriend, as the girlfriend was unable to commit to intimate or long-term relationship. Then she discovered that her girlfriend was having an affair, and rather than being able to hold onto the work she had done, the connections within the therapy relationship, or the portions of a separate self ("me") that she had developed, she decompensated into a place where she was severely depressed and simply could not know or act on any of the progress that she had made previously. She was furious and disappointed with me for not finding the "right way" to alleviate her shame and despair and ensure she could feel that she was okay and mattered. She was the abandoned child again and spent all her time sobbing, feeling worthless and helpless. She literally ended up wailing in my office "nothing matters if they do not love you."

I could hear my colleagues saying that she was "borderline" and that she was sabotaging herself and the treatment. I knew that the formative power of not existing for or with a primary other had reemerged to control her perceptions and internal experience. It was a time of crisis for the therapy relationship as well as for the patient. I began to doubt my work with her, and even temporarily switched out of a relational frame to a more cognitively based format! Predictably, this shift did not work and was ultimately experienced as another abandonment by the patient. Finally, I realized that what was reparative was my attuning to her feeling state, rather than attempting to quickly fix it, and then helping her to name and contain her heartbreak as she grieved the loss of another important relationship. She experienced being seen, felt, and understood.

For her, this experience of being able to actively grieve within our relationship led to increased stabilization and regulation, to regaining her new and tentative sense of self. From there, she has successfully moved on to develop other types of connections by becoming a member of groups involved in activities that she enjoys, and finding friendships within those groups. She has also allowed her self to engage in another primary relationship, one where she is consciously working on the in-between of a Me *and* an Us, and she is continuing to learn what that can actually look and feel like.

Summary

For many people with family histories of trauma and sustained attachment ruptures, their childhoods necessitated the impossible and damaging experience of having to choose between self and connection. Most make the forced "choice" to sacrifice self in order to survive in their relational context. With patients who developed in these circumstances, creating a reparative, safe relationship, one that facilitates the integration of "me" and "us," with the clear support for "AND" rather than "OR," is a sacred journey that necessitates patience and an awareness of what connection to others has actually meant in their lives so far. By meeting these people where they are, and attuning with respect for their struggle and survival strategies, our therapy relationship can provide a crucial step toward their claiming a self

and then— experiencing self AND connection as possible, potentially safe, and even an enriching way to live. With the development of this implicit "AND," they can expand this complexity to all the domains of integration, as they heal toward a more coherent internal experience and balanced relational self. The field of Interpersonal Neurobiology and its integrative approach to understanding and treating our patients offers a multiplicity of scientifically supported somatic, relational, mindful, and spiritual approaches to facilitate the healing of this fundamental wound.

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