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Being in Rhythm: Dissociative Attunement in Therapeutic Process

Karen Hopenwasser, MD

ABSTRACT. Dissociative attunement is a profound rhythmic encounter in therapeutic treatment. Attunement is a synchronized awareness of implicit knowing that is nonlinear and bidirectional. Empathically attuned clinicians are like microtonal tuning forks. They resonate with a variety of emotional pitches and will resonate with nuanced shifting of emotional tone. This resonance is the basis of dissociative attunement. Concepts such as empathic attunement, affect attunement, “the unthought known,” “implicit relational knowing,” and “a two-person unconscious” help us to understand unique aspects of projective identification, transference, and countertransference within the dissociative frame. However, dissociative attunements are systemically self-emergent moments in which multiple self-states are shared by means other than projection. Using clinical vignettes, I demonstrate how dissociative attunement can paradoxically appear to be misattunement. By synthesizing scientific and theoretical concepts applied to these clinical moments, we can understand dissociative attunement as a therapeutic tool as well as a pathway to vicarious traumatization.

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What does it actually mean to be attuned? Biologists know that for an organism to survive it must be attuned to its habitat. Physicists know that attunement is a spontaneous synchronization of oscillating systems. Reiki masters use the phrase *reiki attunement* in their course of training. The piano tuner listens to the vibratory sound of each piano string and adjusts strings *in relationship* to one another. Daniel Stern (1985, p. 142) described affective attunement as “the performance of behaviors that express the quality of feeling of a shared affect state without imitating the exact behavioral expression of the inner state.” Heinz Kohut (1976) described empathic attunement as the psychotherapeutic tool for enhancement of self-regulation. Beebe and Lachmann (2002) applied, with exquisite detail, lessons of infant-mother rhythmic attunement to adult psychotherapy. And Colwyn Trevarthan (1999–2000), in his studies of musical, rhythmic attunement between infant and caretaker, wrote of the “polyrhythmia of motive pulses . . . with radical consequences for human imagination, thinking, remembering and communicating” (p. 155).

In physiology we use the term *entrainment* to describe how oscillating systems, having similar periods, fall into synchrony, or phase locking. When male Malaysian fireflies are entrained, their biological rhythm produces a spectacular simultaneous flashing of light. When soldiers are called for service, part of their rigorous preparation involves entraining their bodies to step together in time, what William McNeill (1995) labeled *muscular bonding*. Pacemaker cells in the heart and single motor neuron cells in the brain are entrained to pulse in synchrony. These pacemaker cells demonstrate self-sustaining oscillations. They beat to a rhythm that is self-generated; they facilitate a system that is self-organizing (Pikovsky, Rosenblum, & Kurths, 2001). And although the physics and mathematics of entrainment is nonlinear, the concept is graspable. The heartbeat is something everyone can imagine.

But what do psychotherapists mean when we say *attunement*? We colloquially speak about “being in sync” or “getting the vibes.” In psychotherapeutic process, we use the word *attunement* instead of entrainment. Although physics and neurobiology allow us to understand aspects of developmental rhythmic entrainment, we shift our language when speaking about psychotherapeutic attunement. In this language shift, we lose a full awareness of the embodied, coconstructed emergence of attunement.
When we use terms like *projective identification*, *transference*, and *countertransference enactments*, we are conceptualizing action in a “do to you,” “do to me” manner (e.g., I am having a feeling that is really your feeling. In countertransference enactment, I am being triggered by you). Terms like *projective identification* suggest a boundary violation—something getting in that is not supposed to be there. Much of our discussion about vicarious traumatization focuses on countertransference enactments in the treatment of relationally traumatized individuals (see below). But the mutually held state of attunement is neither a “do to you” nor “do to me” experience. It is a synchronized, simultaneous awareness of knowing that is nonlinear and fully bidirectional. One aspect of this has been conceptualized as “implicit relational knowing,” a form of knowing that is considered unconscious procedural knowledge (Lyons-Ruth, 1999). Integrating observations from infant development research (Beebe & Lachmann, 2002; Stern, 1985) with relational psychoanalytic theory (e.g., “the unthought known”; Bollas, 1987 and the “intersubjective third”; ogden, 1994) has yielded the model of a “two-person unconscious” (Lyons-Ruth, 1999). For those of us who work with dissociative disorder patients, this model of a two-person unconscious can be a substrate for a much more elaborate conceptualization of implicit relational knowing. Even with careful attention to the dyadic regulation of affect (Fosha, 2000, 2003), we can sometimes get lost in the maze of dissociative shifting. In our work with perpetrators, we are subject to an extreme form of mutual influence which Sue Grand (2000) calls “dissociative malignant contagion,” a dialectical system of knowing and not knowing malevolence. How do we apply these concepts of co-constructed enactments in our therapeutic process with dissociative self states? We must appreciate the essential interconnection of scientific and clinical theory. We must remember that empathy is not always compassionate. Launching from the point of dissociated knowing as opposed to unconscious knowing, I discuss the experience of multiple attunements in any given moment as well as shifting attunements over time.

**REVIEW OF LITERATURE ON INTERDISCIPLINARY INFLUENCES**

In the past decade, a growing literature has addressed the conflicts between the concept of unconscious knowing and the concept of dissociative
knowing. Some of the earliest articles brought psychodynamic process concepts into the discourse on treatment of patients with dissociative disorders. Putnam (1989), Kluft (1984), and Loewenstein (1993) elaborated the concept of traumatic transference. Loewenstein used the term “flashback transference” to describe the inevitable way in which a therapist is perceived as a perpetrator. Chefetz (1997, p. 264) described “the special case transference-countertransference situations of the erotic and traumatic variety.” Su Baker (1997) addressed the way in which projective identification and countertransference enactments are essential for the working through of the unarticulated experiences of trauma. Her metaphor of “dancing the dance with dissociatives” is suggestive of the kind of attunement I describe here. Articles and books began to appear focusing on relational needs of the dissociative patient and relational aspects of the transference (Davies & Frawley, 1991, 1994; Sands, 1994). Vicarious traumatization, understood through the lens of countertransference enactments, was explored (Pearlman & Saakvitne, 1995).

Then, in 1998, Philip Bromberg’s-standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation further forged a bridge between the world of psychoanalysis and the community of clinicians treating dissociative disorders. In addition, authors began to explicitly bring the body into the relational field (Aron & Anderson, 1998; Hopenwasser, 1998; Looker, 1998).

Concurrently, more than a decade ago, researchers in child development began to apply concepts from attachment theory to the patterns of transference and attachment in therapeutic work with adults who had experienced relational trauma in childhood. Liotti (1992, 1999a, 1999b) first described disorganized attachment as an etiologic factor in the development of dissociative disorders. Others described specifically the relationship between disorganized attachment and therapeutic process (Barach, 1991; Blizard, 1997, 2003). And now there is a growing consensus that disorganized attachment is a crucial component of dissociation in children and adults (Liotti, 2006; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006).

The exploration of early attachment style in traumatized individuals was well suited to research, and articles began to appear documenting the relationship between attachment difficulties, early childhood relational trauma, and symptoms of dissociation (Coe, Dalenberg, Aransky, & Reto, 1995; Muller, Sicoli, & Lemieux, 2000).

Simultaneously, the disciplines of interpersonal neurobiology and complexity theory were coming of age. Principles of nonlinear dynamics
began to be applied to psychotherapeutic process (Carroll, 2003; Corrigall & Wilkinson, 2003). Sander described that “[t]he living system is a symphony of biorhythmic systems within systems.” (Sander, 2002, p. 22). With the appearance of the work of Allan Schore (1994, 2003a, 2003b), Daniel Siegel (1999), and Frank Putnam’s (1997) behavioral states model, we began to build a foundation for a scientific discourse about dissociation. Books about stress and posttraumatic stress disorders included chapters addressing the neurochemistry of dissociation (Krystal, Bennett, Bremner, Southwick, & Charney, 1995; Scaer, 2001) while brain imaging studies were addressing the neurobiology of posttraumatic dissociative states (Bremner et al., 1997, 1999; Frewen & Lanius, 2006; Huber et al., 2001; Lanius et al., 2002; Lanius, Williamson, Densmore, & Boksman, 2001; Rauch et al., 1996).

In distantly related fields of neurophilosophy and consciousness studies, authors were starting to apply the neuroscience of brain function to understanding the process of awareness. Books about consciousness proliferated (Chalmers, 1996; Churchland, 1986; Crick, 1994; Dennett, 1991; Edelman, 1992, 2001; Koch, 2004). Neuroscientists started getting into the business of explaining the self (Damasio, 1994, 1999; LeDoux, 2002; Llinas, 2001; Maturana & Varela, 1987; Varela, Thompson, & Rosch, 1991).

Ultimately, we found ourselves involved in multiple discourses about the way in which early trauma influences the development of the brain and mind. Concepts from interdisciplinary studies have filtered into our language, affording a rich but overwhelming expanse of information available to help us formulate our clinical process. Still, the concept of dissociation remains illusive. The average person on the street knows what it feels like but cannot explain it. The medical/psychiatric definition in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994, p. 484) is “a failure to integrate various aspects of identity, memory, and consciousness,” and guidelines for diagnosis are phenomenologically descriptive but fail to capture the depth or complexity of the concept. For the professional, perhaps the most comprehensive and extensive discussion can be found in Elizabeth Howell’s (2005) The Dissociative Mind, in which she maps out the various models of dissociation from defensive adaptation to structural development, from symptomatology to personality organization. But psychodynamically trained clinicians still struggle with an intrinsic conflict between what is unconscious and what is dissociated. The concept of the unconscious perpetuates a Cartesian
split of mind and body that is now under tremendous scrutiny. Bromberg
wrote: “a noticeable shift has been taking place ... away from the idea
of a conscious/preconscious/unconscious distinction per se, towards a
view of the self as decentered, and the mind as a configuration of shift-
ing, nonlinear, discontinuous states of consciousness in an ongoing dia-
ic with the healthy illusion of a unitary selfhood.” (Bromberg, p. 270).
Perhaps ultimately the definition of unconscious will morph into a
form more consistent with advanced neurobiological research. At the
same time, practitioners in the field turn to therapeutic techniques that
recognize embodied expression of traumatic memory (Levine, 1997;
Ogden, Minton, & Pain, 2006; Ogden, Pain, & Fisher, 2006; Shapiro,
1995; Twombly, 2005). Although no therapeutic technique constructs a
comprehensive theory of mind–body continuity, each one offers a dis-
tinct lens through which to understand the embodiment of awareness.
And each practitioner is ultimately using attunement in a finely honed
manner in clinical practice.

DEFINING DISSOCIATIVE ATTUNEMENT

Is this just a new term for a familiar phenomenon? Well, yes, in some
ways. We have all walked out of sessions in which we know good stuff
happened, but we can’t really explain. Or we know something feels bad,
but we are too confused to organize it into words. Just as our patients are
constantly learning things about themselves that they already know, we are
formulating concepts about our work that we actually already know.

The definition of dissociative attunement will emerge through the
presentation of scientific data as it is relevant to clinical practice. The
formulations in this paper are dependent upon an understanding of the
physics of resonance and the biology of entrainment. The experience of
dissociative attunement is a widely shared phenomenon, not necessarily
pathological. Outside of the consulting office it is manifest in team
athletics, performance ensembles, group acrobatics, to name a few. In
psychotherapeutic work, empathic attunement, dissociative transfer-
ence, and affective resonance are all components of dissociative attune-
ment. I explore the spectrum of attunement, from healing process to
vicarious traumatization, from useful relational enactments to mutually
shared disappointments, via the presentation of two clinical moments.
One demonstrates a treatment impasse mistaken as a misattunement
with a patient who seemed to have every reason to leave but who chose
to continue and ultimately work through the impasse. The other demonstrates the range of dissociative attunement in a patient with dissociative identity disorder. I present these moments with few details about each patient as I believe details would overwhelm the delicate architecture of these resonant states.

**THROUGH A GLASS DARKLY**

Based upon a two-person model of psychotherapy, the course of treatment with Marina manifested many moments of what could have been seen as rupture and misattunement. What is most relevant to know about her is that she is a very successful artist who experienced extensive relational trauma in childhood that was then reiterated in adult life. Although she never conceptualized herself as abused, and she is far from a fearful person in her daily life, she often feels persecuted and helpless in relation to larger social forces. At times she would speak about her “meanness” coming from a place of envy. She entered therapy wounded from a previous treatment rupture, believing that her “meanness” was responsible for the termination by a beloved therapist. She was determined to prevent such rupture from happening again.

From the very start of Marina’s treatment I felt as if I were holding my breath in anticipation of the inevitable reenactment that would befall our work. She did not arrive with a diagnosis of dissociative disorder, nor did she manifest symptoms of abrupt internal state shifts. However, time and again, I would be caught unaware in some perceived persecution. Something I would say would leave her feeling shamed or diminished. At first I thought this was simply her defense against connection, a bold retort that it was unsafe to feel close to me. But over time I became painfully aware that a more complex, unarticulated phenomenon was at work. Even with my caution, one way or another I was managing to say something that was unbearable for her to hear, as if I had never learned from the last time it happened.

At the same time, the therapeutic alliance was growing strong. There were countless moments of ordinary reflection, a gradual unfolding of Marina’s early relational history and affective memory. There was evidence of alleviation of underlying suicidal feelings. I felt connected and tormented simultaneously, knowing each interaction could turn inside out without warning. Despite the sudden moments of seemingly
misattuned statements, I don’t think anyone observing would have described our relationship as misattuned.

And yet, after several years the inevitable rupture arrived. During a session in which I was experiencing a relatively relaxed feeling of connection, not only had I said something that shamed her, but it was a self-disclosure that inadvertently and inaccurately revealed a sense of well being in my life, triggering intense envy within her. Contained within my sense of connection was a latent sense of danger, perhaps triggering a need to protect myself. Not only had I said something that shamed her, the first thing I realized was that this was dissociation at its most subtle presentation. I was so accustomed to patients with more florid symptoms that I had somehow underestimated the dissociative nature of our interaction. In so many years of “knowing” myself as an empathic clinician, it was “unknowable” to me that I was participating in meanness. I was a seasoned clinician. I knew when stressors in my life were wearing me down, when undercurrents of frustration or fatigue were leaking through. I was doing everything they say you should do to prevent vicarious traumatization. And yet, every now and then I would open my mouth, words would spill forth with only the best intentions, and wham—Marina would feel punched in the stomach.

Why don’t I call this projective identification? Because Marina understood her own capacity to be mean, understood its role in her previous treatment, and because under the right (or wrong) circumstances of extreme stress I can fully call the meanness my own. I can certainly connect to the sense of helplessness and own the urge to protect myself in the moment. I could describe this as countertransference enactment—although never justified, sometimes inevitable. But the repetition of these painful encounters suggested to me a shared process beyond countertransference yet still outside of our jointly held awareness. It felt like a jointly dissociated awareness that was actually a function of attunement, rather than misattunement. I was not missing the mark in my comments. I was hitting a bull’s-eye over and over again in some kind of reckless precision that stunned us both.

Over a period of many, many months I opted to work with my reiterated meanness the way one would work with internal perpetrator parts. I never blamed her for the provocation or attempted to help her understand this as a coconstructed catastrophe. Instead I struggled to sit with the urges to rid myself of shame and guilt. It became clear that an underlying attunement would allow her to sit with me, with my shame and guilt, with her shame and guilt, together in this whole miasma of relationally induced
shame and guilt. Simultaneously I reflected on my own countertransference issues, simply acknowledging to her that I was reflecting, but never sharing the details. I felt cornered. It was a self-disclosure that had triggered the deepest injury. I could not reveal my own process without risking yet another reenactment.

Eventually, the shared dissociated inner experience of perpetration became available for examination. Marina began to speak about the first therapy disaster as a coconstructed debacle. She no longer believed that she was guilty of such meanness that no one would want to continue to work with her. During the months that I was waiting for her to decide if she should abandon me, she realized that I was not going to abandon her, as had happened with the previous therapist. For close to a year Marina and I sat in a state of dissociated internal perpetration that was finely attuned. This attunement held us like gravity to each other. We both suffered, we both struggled, but enough of the time we could both remember that neither of us was solely malevolent. Many months lapsed before we examined the regrettable moments of injury in our relationship. During these months the work continued on other fronts, with an unspoken agreement that we would wait for the right time to revisit what had happened. Eventually we began to weave in and out of reflections on our attuned experience of perpetration. We would wonder together if we could recover or if the injury was irreversible. I no longer felt vulnerable to her retaliatory envy. Sometimes she would catch herself as she was about to retreat via an acerbic comment, or afterward would call to say she wished she did not need to do that. I began to feel connected without the torment that had characterized our interactions previously. And I believe it was this dissociated attunement that allowed us to stay connected through a mutual inner experience of perpetration.

**AGAIN, WHAT IS ATTUNEMENT?**

Attunement is a rhythmic encounter that is entirely dependent upon being present in the moment. When a parent sings to an infant, cells within the infant brain respond to the sound as if it were an auditory mirror. These cells, in the frontoparietal region of the brain (a center of sensorimotor integration), fire when action outside of oneself is represented in the mind. Called mirror neurons, these cells respond to the sound of action as well as visual stimulation. While mirror neurons exist bilaterally in the cortex, the sound-stimulated mirror neurons are
lateralized to the left, where there are multimodal mirror neurons (Iacoboni & Dapretto, 2006).

Related to the function of mirror neurons, there is a deep structure of the brain, the lobus insularis (insula), between the temporal and parietal lobes, that is associated with the experience of empathy—feeling another’s feelings. Functional MRI studies have shown particular activation of this region in empathic individuals. “Empathic individuals exhibit nonconscious mimicry of the postures, mannerisms and facial expressions of others (the chameleon effect) to a greater extent than non-empathic individuals” (Carr, Iacoboni, Dubeau, Mazziotta, & Lenzi, 2003, p. 5497, italics in the original).

Empathic attunement is predicated upon the activation of neural networks within the brain that are directly stimulated by the experience of seeing, hearing, and touching. When these activations stimulate somatic sensations without mental representations it can be called “body empathy” (Shaw, 2003), which might be understood as a somatic projective identification. In the insula, just alongside these neurons that facilitate empathy, are neurons that influence heart rhythm (Ay et al., 2006; Cheshire & Saper, 2006). The interconnectedness of mirror neurons, heart rhythm and emotional tone reveal a level of coherence that is reflected in folk knowledge over centuries. Perhaps it is with intuitive wisdom that we use statements like “in my heart I know” or plead with someone to “have a heart.”

Empathically attuned clinicians are like microtonal tuning forks. They resonate with a variety of emotional pitches and will resonate with nuanced shifting of emotional tone. This resonance is the basis of dissociative attunement. Dissociative attunement is neither intrinsically therapeutic, nor intrinsically traumatizing. It is simply an implicit knowing of information within the therapeutic relationship that may or may not be available for mindful awareness. However, in the patient with a dissociative disorder the state changes may be so swift, and so nonlinear, that it is impossible to track and therefore impossible to reflect upon as it is happening. If the state changes are too swift for reflection, then it is extremely difficult to stay empathically attuned. In contrast, in a dissociative attunement, the therapist–patient pair can resonate in a syncopated rhythm that allows for an embodied connection, despite much mental confusion. Even with a momentary loss of empathy, the pair can stay attuned. In the next case I describe this experience of dissociative attunement with a patient diagnosed with dissociative identity disorder.
PLEASE HOLD ME—BUT DON’T EVER TOUCH ME

Francesca also came to me from a previous treatment. But unlike Marina, Francesca felt loved and nurtured by her former therapist. She had spent more than a decade feeling supported in her efforts to leave a violent and sexually abusive boyfriend. And though she had shared with her therapist details of extensive early emotional, physical, and sexual abuse as a child, she had managed to hide her inner experience of multiple self-states. When her therapist realized that the long-term treatment had reached a plateau, she sought consultation for her patient. Consequently, Francesca began to transition into treatment with a team of specialists in dissociative identity disorder. Her first therapist remained in the picture as a foundational support, but ultimately the intensive therapeutic work shifted.

Despite evidence of extensive structural dissociation, Francesca was a highly functioning professional and parent. Like Marina, she suffered unbearable chronic, psychic pain and had a deeply held belief that the mean, revengeful parts of her were her “truest self.” Whereas Marina’s “meanness” always felt like a coherent expression of her inner state, Francesca’s “meanness” always felt compartmentalized and more childlike. Only certain parts were capable of being mean.

During the first years of treatment she avoided eye contact from the moment I entered the waiting room through the moment she left the session. She would turn her chair to face the wall so that all I could see was the back of the top of her head. If by chance I passed too closely to her chair, she would unleash a sound of agony. It took me months, maybe years, to learn to read her switches without face to face contact. Now and then she would make it easier for me: a left hand, middle finger raised into the air that told me KC had arrived to save the day, to tell me to shove it.

For years she made no progress in tolerating eye contact or being in close proximity. In the absence of visual cues, sometimes I found it difficult to feel connected. On those occasions, if she entered discouraged and irascible I would get irritable myself. How was I supposed to be helpful when she was fixed in her trance logic mind shielded by the back of her head? She was constantly complaining about not making progress and simultaneously refusing to acknowledge any emotional connection with me.

Yet this experience of sitting with Francesca, without eye contact, sometimes with very few words exchanged, taught me that a different
kind of knowing was happening. I could feel her empathy. How did I
know this? While the neuroimaging studies I cited above help us to corre-
late brain activity with feeling states, they do not explain the subtleties of
interpersonal relationships. And while some people claim to be able to
notice somatic resonant energy, I am one of those who is mystified when
my yoga teacher talks about pulsing chakras. What I did know, is that I
was aware of feeling safe in the moment. Often she would express
authentic interest in a dyadic interaction. Despite her denial that there was
any real attachment, I was becoming increasingly certain that a profound
connection had been established and that this was a mutually shared
awareness that could not be articulated. This awareness was transcen-
dent to the multiple transferences and countertransferences that would
weave through our intense and confusing therapeutic work. On occasion
I felt pushed to the point of exasperation. She would react to empathic
comments with writhing pain. Empathy played out as misattunement. If
I obeyed her command to “never be nice” she would ridicule me as
incapable of nurturing. Trying to protect her from pain played out as
misattunement.

There were reiterative moments of dissociated transference enact-
ments, and a few too many countertransference enactments when I
would get triggered and offer a stern reprimand, indicating I had had
enough for the day. In sessions when I remained more patient, she
would beg me to become irritated, cleverly proposing that that was the
only way she could really feel a connection with me. But throughout
these shifts, there was what felt to me a remarkable attunement between
us. There would be a window of perhaps 10 or 20 seconds during which
time I could sense Francesca’s imminent shift. There was no opportu-
nity to pause and actually think. The experience for me was quite simi-
lar to another familiar process, that of playing music in a chamber
ensemble. When I recognized the similarity, I understood that Francesca
and I were being in rhythm in a synchronized way moving through time.
What might have appeared to others as misattunements were in actuality
syncopated, synchronized shifts through multiple self-states, not unlike
the improvisational yet coordinated polyrhythms I was learning in my
musical studies.1

My work with Francesca has focused predominantly upon these
moment-by-moment shifts, hovering intermittently in anguished memories
of early abuse. It is my speculation that my ability to stay connected and
regulate traumatic abreactions was entirely dependent upon my willingness
to listen to implicitly derived knowledge and at times to abandon the
caution that accompanies reflection. This was made possible by a deeply embodied sense of trust that was mutually held and bidirectional. Francesca and I could travel together to the edges of a treacherous inner landscape because we were dissociatively attuned.

Eventually, the embodied trust allowed us to use innovative treatment techniques that have facilitated limited eye contact. With steady progress various parts have been able to tolerate feeling “touched” by me. When I asked her permission to write about us, she requested to read what I wrote. Instead, I read aloud to her this section of the paper, rather than have her read it alone. Still faced with the back of her head, I could sense that she was listening with several parts of her self. Her first comment: “Ya got it.”

CONCLUSION

Sufi Master and musician Hazrat Inayat Khan wrote the following:

Rhythm is life disguised in motion, and in every guise it seems to attract the attention of man; from a child who is pleased with the moving of a rattle and is soothed by the swing of its cradle, to a grown person whose every game, sport and enjoyment has rhythm disguised in it in some way or another. (Khan, 1991, p. 151)

All existing things that we see or hear, that we perceive, vibrate. If it were not for vibration, precious stones would not show us their color and their brilliance; it is vibration that makes trees grow, fruit ripen, and flowers bloom. Our existence is also according to the law of vibrations, not only the existence our physical body but also that of our thoughts and feelings. (Khan, 1983, pp. 6–7)

For some, this concept of dissociative attunement will make sense on a spiritual level. For me, it also flows simply from physics and neurobiology. I am proposing here that mindfulness (i.e., being present) is not in itself protection against vicarious traumatization. Although there are specific cases of vicarious traumatization secondary to projective identifications and countertransference phenomena, there is a general problem of vicarious traumatization due to being present in the dissociative field day in and day out. How do we process these moments of attunement so that we do not exhaust ourselves? In addition to heeding the advice of those who have been there (Figley, 2002; Rothschild & Rand,
2006; Saakvitne, 1996), we must attend to our own body rhythms, particularly as they shift over time. I was taught to try to be steady like a rock for my patients. But rocks we are not. We must track our own regulated and dysregulated, synchronized, pulsating selves. When we focus on the painful moments of misattunement or therapeutic error, we must also consider, in some cases, our simultaneous participation in a subtle, rhythmically synchronized attunement. This enables us to stay connected rather than lapse into what Leighton (2004) described as a shame-induced “one-person system.”

What was vicariously traumatizing in my work with Marina was that I did not know how unsafe I felt in those moments of connection. My attunement with her internal perpetrator triggered my own dissociated defensive maneuver. We did not begin to feel safe with each other until we entered into a shared, mutual state of grief. One of the greatest challenges in working with individuals who were terribly mistreated as children is enabling a process of mourning. When we bring our own rhythmic ability into the mourning experience we are facilitating healing in an implicit, embodied manner. When we sit with our patients in a state of mutual grief and disappointment, we are utilizing dissociative attunement in its most therapeutic form.

For clinicians, the consilience of knowledge that now informs our work allows us to leap forward in our understanding of therapeutic process and dissociation. The concept of dissociative attunement transcends the model of dissociation as pathology and highlights rhythmic attunement as not just a healing moment, but ultimately a healing force sustained over time. Yet there remains much we cannot explain about the mysterious process of healing unbearable pain. Sometimes the only words that resonate for me are those of the poets, such as Mary Oliver (1986), when she wrote the following: “Everyone knows the great energies running amok cast terrible shadows, that each of the so-called senseless acts has its thread looping back through the world and into a human heart.”

NOTE

1. Special thanks to my friend and teacher, Layne Redmond, whose “Walking and Breathing Meditation” was my first introduction to the meaning of “Being in Rhythm,” and much appreciation to my frame drum teacher, Eva Atsalis, who patiently led me toward really getting it.
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