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CHAPTER 16

Imagery in the Treament of Trauma

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> It appears your complaint stems from all these things that you told me that happened, all these memories that you have of these things that you say happened; and so would you be different today, would your situation be different today, if your memories were different?
>
> David Grove (in Grove & Panzer, 1984, p. 99)

A trauma is a psychological wound, which time did not heal. That wounding has not been integrated adequately in the person's organism and continues to influence the person's life in a negative way. The negative experience continues to hurt and is reactivated periodically. Most of the time the person has dissociated from the memories or feelings of the occurrence or series of occurrences. This is particularly true if the pain is unbearable. The dissociation is a psychological rescue attempt to escape the painful feelings. The person is "somewhere else" so that he/she can continue to live his/her life (van der Hart, Steele, Boon, & Bliss, 1986).

That "going away" or splitting from the pain has two major consequences: The person will try to avoid everything that is associated with the trauma (generalization) and, paradoxically and unintentionally, will thereby maintain the presence of the trauma. It helps the client to feel the pain less acutely, but it also will result in the wound remaining infected and continuing to exert negative psychological and often physical influence. These feelings and memories often occur in the form of images. Images are building stones of the human psychological experience, and negative images often play a dramatic and central role in Posttraumatic Stress Disorder (PTSD). It is therefore understandable and logical that imagery is widely used in the treatment of trauma. Exposure to traumatic memories through the use of imagery is frequently and effectively used as a procedure in many therapeutic approaches. However, therapeutic approaches

using imagery also can have serious dangers. These methods can destabilize a client and therefore should be handled by the therapist with great care and in continuous consideration of the needs and possibilities of the client. Confrontation with traumatic images is not a medicine by itself and should not be a goal in itself. When it is used, it always should be embedded in the overall goal, which is better adaptation and functioning in the client's present life situation (Taal, 1994).

WHY IMAGERY?

Imagery is a particularly useful and effective method in the treatment of trauma because of several reasons:

1. Spontaneous images related to the traumatic events often are an important part of the person's complaints, psychological and social suffering, and therefore constitute an important psychological field to work in. An example may illustrate this: Every time Fred drove his car near the particular town where his best friend died in a motorcycle accident, he "saw" images of the accident and of his friend dead on the ground, although in reality Fred had not been present when it had happened. Each time great sadness would rise up in him, he would start to tremble and would have to stop his car.
2. Words only partly express and represent a person's inner experience. Images provide a more comprehensive picture of what matters.
3. Extremely distressful and frightening situations can be expressed and worked on in a metaphorical and symbolic form, without the necessity to mention all the details. What a client verbally does not dare to say or is unable to do, often can be expressed in images or in a metaphor of some sort. Another example: Carol talks about this dark shadow she so often feels on herself, immobilizing her. Without telling exactly what the dark shadow represented, she was able to gradually deal with the shadow. In the beginning she did not fully know what or whom the shadow represented. During the imagery work (like drawing the shadow, talking to the shadow, taking the place of the shadow), her understanding of it became clearer.

Eventually she came to see how the shadow played a role in her history. Even though she was not able to verbally express the related historical events until much later, she was able to stand her ground vis-a-vis the shadow, even push the shadow away and become less immobilized by it.

Some clients will never get to the "exact facts" related to the trauma from which they are suffering; yet, they become much better in dealing with it through imagery. These images may not truly represent what actually happened; however, the historical truth is not as important as what the client thinks happened. The client will not react to the historical truth but rather to what he/she imagines it to be. When that becomes apparent to the therapist, it is usually not productive to confront the discrepancy. Historical truth and inner experience belong to two different realms. It is wiser to stay with the image the client presents, historically

accurate or not. For a client it may be essential to be "believed" by the therapist. When the client asks the therapist, whether he/she believes that it really happened this way, the latter may say: "I believe that what you tell me, is what you believe has happened. Whether this is historically true does not matter to me." Ours is not a legal profession.

4. Certain symbolic images may exert a beneficial influence on the client and help the client to fortify his/her identity. The image of the sun often helped Carol in difficult times. Concentrating on the internal image of a sun and on a drawing she made of a sun helped her in two ways. It helped her counter the negative emotional influence of "the shadow," and it promoted feelings of warmth and trust in herself.

THE IMPORTANCE OF I-STRENGTH AND STRUCTURE IN DAILY LIFE

The procedure most mentioned in literature on treatment of trauma is "imaginary exposure." However, as an isolated procedure, it is usually not effective and even can be harmful. This can be the case when the I-strength of the person (ego-strength) is not sufficient. The "I" is the faculty within a person that takes care of the integration of experiences and emotional balance. In order to help the person to cope better with the traumatic images, the person needs to be trained to integrate the emotional and psychological influences the images exert. He/she needs capability and strength to handle these contents. A client wrote this reflection: "As long as I was not conscious of the traumas that had occurred in my life, I was in a frozen state, stagnant. In the course of my life only more ice accumulated. Now, as I am thawing, I start to see and feel what happened. That hurts a lot and scares me. Maybe in a while, new things will develop or latent qualities come to life, but now I need 'grip.' I need a goal for the future or else I become overcome by depression and intense pain."

Treatment of trauma should initially focus on better coping with day-to-day life, thus creating the right conditions to approach traumatic psychological material directly. In cases where there is not enough I-strengh and an exploration of traumatic content could lead to decomposition of the personality, any direct approach to traumatic content is to be avoided.

Therapy should then restrict itself to coping with concrete day-to-day life issues. It is necessary for the client to develop a structured basis on which to fall back and from which to derive strength.

Dealing with traumatic material and using revealing imagery comes later. An example again: John, a shy, unkemp 40-year-old man, was having difficulty with relations and finding a proper place in society; he had no job, for instance. In the first interview John mentioned that he had lost his father at the age of 7. The death of his father, the person he had been very fond of, changed his life dramatically. His mother was unable to run her family of John and his four brothers and sisters.

John, who was also handicapped by a vision problem, was put in a residential home. When he came out of the residential home, at age 15, he was emotionally withdrawn and felt unwanted and inadequate.

It seemed evident that the loss of his father was one of the major sources of his problems today. But talking with the therapist about that event and remembering what happened then, caused him great distress. When he came home after the session, he did not eat for days, did not wash, and did not show his face to anyone. Only when he did not show up for his appointment the next week, did the therapist realize the gravity of John's condition. Talking about the death of his father brought up such an overwelming flood of images and feelings of loneliness that he was literally unable to move or take care of ordinary daily actions.

During the following 2 years, the focus of the therapy was on helping John to structure his life, to learn to take care of himself, to learn the importance of taking the time and trouble to wash his body and his clothes regularly, to cook a proper meal at least five times a week, and to clean up his house. Eventually John, stimulated by the therapist, found some voluntary work in a home for the aged. During all that time, the death of his father was never brought up.

What was needed first was to establish more structure in his day-to-day life. Although the historical source of his distress was not treated directly, his strength and position in life had improved to the point that John could develop some friendships and even found a job that satisfied him.

I-STRENGTHENING STRATEGIES

For this phase of the therapy, the following strategies may be of use:

1. Promote and repair the adaptive capacities in daily life. Pay attention to meals, personal hygiene, keeping a clean house, safety, etc.
2. Enhance self-esteem.
3. Develop positive perspective; improve areas of complaint. Foster new hope.
4. Stabilize symptoms and complaints, check medication if indicated, possibly in tandem with the client's physician.
5. The therapist should practice active listening ("I hear you").
6. Focus on positive aspects of the present and the future.
7. Practice healing imagery. For example, after some relaxation: "Imagine yourself in a comfortable place, maybe in nature, maybe somewhere else. Go where you really feel safe and at ease . . . . Notice how this place looks . . . . Feel the beneficial atmosphere . . . . Let it enter your body . . . your cells . . . relax in the safety of this place . . . smell the smells . . . hear the sounds . . . . Make this a place you always can come back to, for comfort and to deeply relax."

8. Give homework (writing and other assignments). Be sure to come back to it at the next session. Honor the work done.
9. Redefine the client from "victim" to "survivor."
10. Make use of transpersonal energies. In the literature various names are given to these—for instance, center core, internal self-helper, higher self, spiritual helper, guide. It is amazing how many severely traumatized people mention the presence of transpersonal energies. Example: A client who had been misused by her father during a substantial portion of her childhood, reported that there always had been "an angel singing psalms to her." She felt it had helped her survive. Another client reported seeing a light: it would appear when she needed it most. Others find solace in going to a place where there is no pain and no suffering. A good way to access these energies in a client is to ask: "What helped you survive, what sustained you?"

    Transpersonal energies can nourish and support clients and can help them to develop meaning and identity. Sometimes, however, transpersonal energies can cause an unbalance. They can facilitate dissociation. In those cases the client can be helped to develop other capacities as a counter force. For instance, by learning to be more assertive, a client who generally seeks refuge in "heavenly visions" will have the option to stand his/her ground rather than to flee.

DEALING WITH THE TRAUMA ITSELF

Imagination can be an eminent technique in the healing of traumas. The work-through consists of contacting the original events, feelings, and/or traumatic images and then correcting what seemed to be dysfunctional in the response of the client at that time. The following steps can be discerned in the process:

1. Recognizing and Acknowledging the Importance of the Trauma. Is there still a negative influence in the present life of the client? Often the client is unclear about the extent of the damage, denies or diminishes the influence the trauma still has. This often springs out of powerlessness and fear. Only when the person is sufficiently convinced of the seriousness of the trauma, can he/she develop the necessary motivation to venture the work-through.

2. Context and Diagnosis.

a. Evaluate the client's context, background, daily life.
b. What trauma does it concern? How much insight and awareness is there? What are any situational triggers? What are the physical sensations or complaints?
c. Is the client motivated to work through?
d. What is the desired state? What can be achieved? How feasible is a work-through?

3. Anchoring. Before commencing the actual viewing of the traumatic events, the client needs to be taught to "anchor" in his/her body and in the here and now. This will make it possible for the client to come back when being overwhelmed. He/she knows how to return to his/her body and this "safe spot." A procedure to do this follows: The client, sitting in a chair, is helped to become aware how the feet rest on the ground, how the body is supported by the chair, how the breath flows in and out. Once the client has reached a satisfactory degree of relaxation, he/she can be asked to touch a part of the body (the pulse, the elbow) and symbolically anchor this feeling of relaxation. Whenever he/she becomes too tense or overwhelmed in the work-through, he/she can now touch this spot and return to relaxation. It is also possible for the therapist to provide anchoring by touching the client, when it seems necessary.

4. Admitting the Feelings Related to the Traumatic Events. Is the person prepared to face the feelings that possibly could emerge? Ask for instance: "What is the worst you could discover?" "And do you think you can handle that?" Explore little step by little step the association with the feelings that are related to the traumatic events and the gradual letting go of dissociation.

5. Reliving or Reviewing the Traumatic Events. Various forms and gradations are possible. Initially it may be necessary to keep a distance from the traumatic experience. The client can regress and slip back into the "overwhelmed victim" position. That is usually not desirable. Keeping distance may be achieved by instructing the client to let the images appear on a film screen. Or the therapist can emphasize that "the current 45-year-old Sandy from her safe position in the chair with her current resources looks at what the 6-year-old Sandy goes through and experiences." Or the therapist can ask the client to imagine that he/she has push-buttons to control the film, when he/she wishes.

Some therapists ask the client to go back and reexperience what happened. That requires much I-strength from the client. The therapist in that case may end up becoming a good parent who helps the client recover from the painful experience.

It is important to pay close attention to the decisions the client makes under the influence of the trauma. The therapist should distinguish between a "bad experience" and a trauma. In a "bad experience," the belief system of the client stays intact and the client can integrate the experience without major changes in his/her belief system. In a trauma, the client can no longer maintain his/her belief system. It shatters, and for his/her own protection the client now makes a life decision that may be life-denying and seriously narrows the choices that are available. Again an example: Jannie, 30, was not able to establish a meaningful relationship with a man. Every time the encounter with a man, even a desirable man, came to the point that sex became a possibility, she froze and had to interrupt the experience, even walk out of the room. She consciously wanted to have sex but could not handle it. In the therapy, she made a connection between

her fear of sex and being molested when she was 8 and 9 years old by an uncle who lived with her family.

She was asked to review one of these episodes and she reluctantly agreed. She was afraid to "go back to the scene of the crime." She was sure that she would fall apart.

The therapist, noticing this fear, decided not to go ahead, even though she had agreed. He explained that it was not necessary to feel the way she felt at the time of the molestation. In fact that would be undesirable. She would not relive the experience. She would review what had happened to the 8- and 9-year-old Jannie, while the 30-year-old Jannie remained in the safety of her chair and in possession of her current resources. At any time that the experience became too much, she or the therapist could stop the experience and relax again.

She now indeed was able to review a whole episode without too much trouble. Two or three times the therapist had to say, "as the 30-year-old Jannie in her chair in this room now sees what 8-year-old Jannie goes through . . . ," to prevent her from regressing. When the uncle had left the room and 8-year-old Jannie was left bewildered, the therapist now asked 30-year-old Jannie to see what was going on for the 8-year-old Jannie. What did she think, feel, and what decisions did she make? Adult Jannie thought that 8-year-old Jannie felt she was dirty, that her genital area was dirty, and that she never wanted to touch "that" again. Also she never wanted to be in a room alone with a man.

It was not difficult for the therapist to see the connection between those decisions and her inability to engage in anything that came close to sex. But this was not the time to try to make that connection overt. Instead, the therapist now asked Jannie what she thought the 8-year-old needed to hear. Jannie needed to hear that she was not dirty, that it was O.K. to touch her genitals, and that later, when she was grown up, she could have sex any time she wanted and enjoy that.

Now the therapist asked Jannie to say that directly to young Jannie, which she did. The therapist then asked Jannie, if she thought young Jannie understood. "Yes, except for that about enjoying sex; she is too young to grasp that." "What do you want to say now to young Jannie?" Jannie was not quite sure how to respond to Jannie. The therapist offered: "Would it be O.K. to say to Jannie that it is O.K. that she does not understand that now, but to just remember that for later?" Jannie nodded and said to young Jannie, "Your uncle was wrong in what he did. This is your body and no one should touch it the way your uncle did. But when you grow up, I hope that you can remember what I tell you now. You can enjoy this with the right person. Remember that for later." "Does young Jannie get that now?" "No, but that is all she can now understand about it." "Anything else you want to tell her?" "Yea, I love you, you are O.K."

This dialogue between little Jannie and adult Jannie is in essence a reprogramming of the belief system that was scrambled at the time of the molestations. For the therapist, it is essential to see to it that adult Jannie does not regress and start feeling like 8-year-old Jannie. The therapist can facilitate that by always

addressing the adult Jannie. For instance, the therapist should not ask, "How do you feel?" but rather "What do you think 8-year-old Jannie feels now?" The whole process is conducted via adult Jannie. Also the therapist should try to make the dialogue between the adult and the 8-year-old Jannie as direct as possible; for example, "Tell her that . . ." (Krop, 1981, 1997).

6. Recovery and Reintegration. It is evident that one experience like this, impactful as it is, is not enough to establish a new belief system that is life affirming. It may be necessary for the client to repeat the process a number of times and maybe even to go through scenes, later in her life, where she experienced the same feelings. It also may be possible now for the client to imagine future scenes, where she is able to have a positive intimate encounter with a man. It is not possible to forget the traumatic experiences or to pretend that they did not happen. But where there was a wound, there is now a scar, and people can live quite well with a scar.

7. Implementation. It is necessary now to try out if the changes indeed show up in the daily life of the client. Therapist and client now can explore possible scenarios where the client exposes himself/herself to a clearly delineated experience. For instance, in the case of Jannie, to allow receiving or giving a massage that can include as much or as little of her body as she wants can be helpful.

Of course these steps do not always follow in this sequence. Another example, in which the elements mentioned above can be recognized, though not necessarily in sequence, follows. Anita is 43 years old. At the age of 6, she was lured to the attic by her neighbor and sexually abused. Only recently did she remember that this took place. It was repressed for years.

Thinking back to this event is accompanied by great anxiety; she hardly dares tell me what happened. It is the first time that she shares this with someone. Repeatedly her throat tightens; as if she is being strangled. Later Anita tells me that her neighbor indeed throttled her throat to prevent her from screaming. It is not essential for the therapist to hear every detail of what happened. Anita can make contact with what occured in her own way.

As Anita talks about what happened, she occasionally disconnects from what she tells. She "floats away to a far land where she is alone and feels nothing." The exploration of this experience through the images and accompanying feeling occupies a number of sessions. Anita notices that "not being there" in a way provides safety but also causes her to "not always live fully." She realizes that this also occurs in her sexual life. She detaches, feels nothing, and floats around in that far land.

At the time of this occurrence, Anita's mother was seriously ill and not available to Anita, and she did not feel that she could tell her father what had happened. The inability to talk to anyone about this added significantly to the pain and anxiety of the sexual abuse. That she now can talk about this is of great importance

in itself. Later in imaging what happened, the therapist goes with her to the attic and protects her against this neighbor, and thus takes the position of the available, protective adult—a kind of "ideal parent." Holding her hand, in a combination of imagery and psychodrama, the therapist goes with her up the stairs to the attic and she describes the terrible things the neighbor does.

In the beginning she slips readily back into the pain and fear, becomes the child of then. She cannot feel the therapist's helping presence and "floats away" again. Gradually she comes to see the therapist as the adult who interferes and protects her, and she can allow herself to stay and see what happens between the girl and the neighbor. She begins to develop some perspective on what happened.

In the next phase, the therapist asks Anita to take the position of the "ideal parent." Gradually Anita learns to become an "ideal mother" for the traumatized child. This brings her to a crucial phase where her I-strength allows her now to do the confrontation herself. For the first time she manages to open her throat, express her anger, and scream. In her fantasy, she kills the neighbor and cuts him to pieces. (In reality the man had died years ago.) Now that she is operating out of her own adult position toward the trauma, the therapist can step out of the role of "ideal parent."

More and more she experiences herself as an adult and can take care of the 6-year-old who had suffered so much and had felt so alone. She also made a number of real changes in her life. A year later she moved into a new flat, and for the first time in her life she felt that this flat was really hers; she also went back to school. She reported that she was beginning to have faith in herself and to believe in a future. Her circle of friends also changed drastically. In a follow-up 2 years later, Anita said that she had started a relationship with a man and that, contrary to her old relationships, she felt that in this relationship she maintained her identity and self-worth.

THE ROLE OF THE THERAPIST

Dealing with a trauma is a complex and delicate matter with many traps, and requires a great deal of sensitivity on the part of the therapist and a careful step-by-step approach. When confronting the trauma, the therapist provides emotional support as an empathetic presence, without in any way forcing the client. A balance has to be achieved between too much and too little stimulation in confronting the traumatic events (Taal, 1994).

A metaphoric picture of the client/therapist relationship could be that of the therapist walking with the client, one step behind, hand on the shoulder of the client. The client leads. When the client stops, the therapist stops and may inquire what is going on. When the client wants to back off, the therapist backs off with the client. When the client does anything peculiar, like holding his/her breath, raising an arm, turning away, the therapist asks, "What is going on now?" Thus the client is not led or pushed by the therapist, the therapist is behind the client

and helps him/her find out what is going on. The therapist is not in front of the client pulling him/her along.

At times, when the client needs protection, the therapist can leave the position behind the client and take an active role, for example, going up the stairs to the attic with Anita. In traumas that occurred at an early age, in particular incest, there is often a serious developmental disturbance. The "I" in relation to the trauma still functions on the traumatized-child level, still feels the same powerlessness in relation to what happened and often has split off from it (dissociation).

It is necessary in the first phase of the therapy to develop a bond with the client. This bond facilitates filling the gaps in the development of the child so that the adult becomes equipped to deal with what needs to be processed. The therapist assumes temporarily the role of a protecting, nurturing supportive parent, who was needed, but was sorely lacking, when the traumatic experience(s) took place.

This has far reaching consequences for the client/therapist relationship. It requires an emotional engagement of the therapist, much patience, and ability to handle aggression or distrust. A great deal of the therapeutic work takes place in the transference with the therapist. Fortunately the countertransference issues that play a role here are more and more recognized. When there is little "I" strength in the client, the therapist can "lend ego" to help the client find the way in all the turmoil inside. Again an example: Gerard was haunted by images of his father pursuing him with an axe. When the client was a child, his father had been aggressive and violent. After the divorce of his parents, which occurred when Gerard was 6, he was raised by his mother. The images of his father with the axe were still so strong, that Gerard locked himself up in his room a great deal of the day. During the night, Gerard at times had violent outbursts during which he broke things and sometimes injured himself. When he was in the last year of his studies, he had quit.

The confrontations with the pictures of his father wielding the axe were intense. In the beginning, Gerard screamed and trembled. It was as if his father were present in the therapy room. At those times, the therapist became a protective, supportive parent to him and, on occasions, would scream loudly at that imaginary father to leave Gerard alone.

His anxiety level decreased bit by bit. The threat of his father, however, remained until Gerard, in an imaginary confrontation with his father, frantically tried to wrest the axe from his father's hands. Initially he did not succeed; yet the efforts, guided by the therapist's support and coaching, gave him more self-confidence. For instance, Gerard now began to ask advice about resuming his studies.

It is possible, and often very valuable, to use a combination of mental imagery and artistic expression (Taal, 1998; Wertheim-Cahen, 1998). Instead of describing the images to the therapist, the client can express his/her emotions and inner experience, and discharge tension. Creative expression provides room for feelings

or experiences that—consciously or unconsciously—are unacceptable to the client. It is often necessary to emphasize that artistic or aesthetic performance is not the aim of the expression. Sometimes clients feel hampered in expressing themselves creatively because of memories of negative experiences, when their work was judged negatively, for instance in school.

To counteract these negative expectations, it is useful to emphasize that the creative work is not supposed to be beautiful. It may also be helpful to do some liberating excercises, such as making "ugly paintings" on purpose.

The choice of materials is important. Each expressive medium has its own possibilities. A client who has a tendency to lose himself/herself in images, can be offered clay, which will help in grounding himself/herself more. Paint gives the client a great variety of shapes and colors. The choice of the size of paper is relevant. The client may be too timid to use a large sheet and may start using a small sheet or the corner of a large sheet; later the client can become more venturesome and draw bolder. Creative expression is an act and asks concrete action of a client.

Thus the ability to participate and take a stand is mobilized. Concretely dealing with the materials, actively choosing an art form and materials increase the client's participation in the healing process and enhance problem-solving capacities. Combining mental imagery and expressive means can make mental images more visible; and vice versa: a drawing, painting, or a created object can in turn lead to further mental images. It often happens that a client's artistic expression already shows what the client is not yet aware of. Six months later the client may say, "Oh, that's what that meant."

There is no question that the expression itself has healing value. There are diverging opinions in the field how much interpretation of the expressive product or the process is useful. It seems safe to ask the client's opinion or even to ask the client to take the place of the objects or drawings and speak for them. It is unwise for the therapist to presume to know what an image means and to insist that the client consider or even buy the explanation.

An example of combined use of mental images and creative expression follows: Vera grew up with much loneliness and anxiety. She sees herself as "a rose that is broken and has fallen on the ground." She is not able to see herself in any other way. The suggestion of the therapist to visualize a stronger, more ideal image is of no avail. The image of the broken rose comes back all the time.

Only when she starts working with paint, a change starts to occur. The therapist asks her to mix colors that for her represent power. Then he asks her to smear these colors on a sheet, then on another sheet which is bigger. She happens to like working with paint and chooses one painting to take home with her to hang on her wall.

In the following sessions she continues doing art work. She works with crayons, paint, cut-outs, and collages around the themes "power" and "rose." The rose remains unrooted, however. On a suggestion of the therapist, she changes the rose

into a rosebush. But the rosebush is continually being pruned back, even leveled to the ground. In a further exploration of how this takes place, "a man with shears who comes to do that in the night" appears. When these images appear she becomes nauseated. After excercises in anchoring (I-strength), she at last feels strong enough to paint this man and, subsequently, with thick stripes to put him behind bars.

Almost always the work with traumatized clients proceeds slowly. In small steps, one thing leads to another. In Vera's case, after the session in which she "crossed out the man," she reported that she had effected a change in her work situation. When that was successful, it reinforced her feeling of power and that manifested itself again in a change in the image of the rosebush. It was no longer pruned back, and new branches and buds began to appear.

SUMMARY

Imagery is particularly useful in the treatment of trauma. Extreme, distressful, and frightening situations can be expressed and worked through in a metaphorical and symbolic form, without the necessity to mention all the details. The treatment entails discovering what is needed to heal the trauma and diminish the pain and the continual regression and dissociation.

In order to effectuate a succesful recovery it is usually necessary to introduce new helpful elements into the images. Special attention needs to be given to the "I"-strength of the subject. One can proceed only if the subject is present enough in the here-and-now and is able to assimilate the emerging material. When the trauma originates from a young age (e.g., incest) there is often a serious disturbance in the development of the personality, which needs to be addressed first.

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