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# Working with psychosomatic distress and developmental trauma

## A clinical illustration

**By Margaret Landale**

> "It's true, we do store some memory in the brain, but by far, the deeper, older messages are stored in the body and must be accessed through the body. Your body is your subconscious mind, and you can't heal it by talk alone." (Pert 1999: 306).

### Introduction

In this chapter I will be talking about psychosomatic distress and how the body can provide a vital resource for the therapy. At base psychosomatic distress refers to unresolved or poorly regulated emotional arousal levels which have a detrimental influence on the main systems of the body such as the immune, hormonal and respiratory systems and of course the ANS (Autonomic Nervous System). This can lead to a whole range of psychosomatic conditions or medically unexplained symptoms (somatoform disorders), ranging from severe headaches, fatigue, backaches and gastric problems to chest or abdominal pains and respiratory problems. And we can include anxiety disorders and depression here too.

Severe forms of psychosomatic distress are often rooted in early childhood trauma and can also manifest as self-harming, addictions, eating disorders and Borderline Personality Disorder (BPD). Clients who suffer from psychosomatic conditions are typically further distressed by both the often chronic and debilitating pain with which they live on a daily basis and by the lack of medical explanation or treatment available. This leads to a vicious circle in which these increased emotional arousal levels further decrease the client's capacity for emotional self regulation and potentially aggravate the symptoms further.

I have chosen a clinical illustration to discuss some of the typical dilemmas which both clients and therapists encounter in this work. Anne's[i] case also demonstrates how by engaging flexibly with embodied, emotional and cognitive processes, significant shifts can occur.

In the context of this chapter I am going to talk about two distinct phases of this work. The first considers how to lower arousal levels by building a practical alliance with the client. This involves providing a rationale based on stress and trauma principles and enrolling the client in developing the necessary practical skills.

The second phase, which builds on the client's ability to monitor and manage their arousal levels, involves a mindful enquiry directly into the symptoms through imaging processes.

**Anne's story**

Anne was in her early thirties when two of her brothers died in quick succession. A few months later she began to experience severe and debilitating pains and spasms in her lower
back and thighs. On several occasions she became completely paralyzed and was unable to move for days or even weeks. Thorough medical checks failed to provide a physiological explanation and over a period of three years she tried a range of treatments to little effect.

Anne was truly distressed when she came into therapy. The ongoing pain coupled with increased fear of loss of movement was taking its toll. She had, however, begun to seriously consider the possibility that her symptoms were emotionally driven and when she heard that I was specializing on psychosomatic disorders, she contacted me.

My first impression of Anne was that of a confident and lively woman. She came across as open and engaging and very articulate in presenting her problems. However, her confident and extrovert manner contrasted sharply with aspects of her body language and

indeed her symptoms. Given that Anne had suffered persistent pain over a long period of time, it was understandable that her movements were deliberate and cautious. Yet there was more to it than this. All her movements seemed carefully planned and carried out in a cautious and highly deliberate manner. The contrast was stark. Here was a bubbly, lively woman – but this aliveness was conveyed almost entirely by facial expression, voice and verbal content. There was some gesturing with her arms as she spoke, but I was struck by how lifeless her hands appeared.

The body can reveal a great deal more about a person's emotional identity than the spoken word. In fact all aspects of body language are a powerful resource for the therapist to glean insights into the client's unconscious. I was curious how these first impressions might relate to Anne's history.

Anne was the third child of four, and the only girl. Her mother was a strong and dominant woman, who brought her children up with firm rules. In Anne's words: "We were all burdens to my mother, to be controlled, washed and dressed". I believe that Anne's mother wanted to do the best for her children, but she was tense and frustrated dealing with the nitty gritty reality of a young family. She was especially intolerant of emotional outbursts or neediness and would not allow tears. Anne also recalls how her mother intervened and stopped her father from cuddling her when she was four, arguing that it was inappropriate to spoil and indulge children like this. Anne, being a determined spirit, did not give this comfort up readily and was consequently nicknamed 'super glue'. Anne

loved her father who was affectionate and seems to have favored her. But he worked away from home for most of Anne's childhood and was therefore unavailable most of the time. Anne's parents argued and fought increasingly until they got divorced when she was in her teens. Her brothers moved out of the family home at this point but Anne decided to stay with her mother.

Following the divorce Anne's mother became depressed and turned to alcohol. Then, just a year later she was diagnosed with breast cancer which ultimately spread into her bones. Anne operated as her mother's sole carer for the next three years until her death. During this time she received very little support from the rest of her family. For example Anne's maternal grandmother, who lived nearby and who was still very active, told Anne that she could not possibly be involved in the care of her daughter because she didn't feel she "could cope with the horror of it all".

Anne's mother was also in desperate denial about the recurrence of her cancer and her doctors colluded in this by telling her that she was suffering from bone calcification. Anne was given firm instructions not to tell her mother about the cancer or indeed that she was dying. Anne was left on her own, watching the slow decay of her mother's body, watching her mother struggle to keep hope alive whilst battling against death. She was seventeen. These were difficult and emotionally overwhelming circumstances for Anne. True to her upbringing she soldiered on through her mother's illness and received praise

for her resolve and strength. However we can guess at the cost. Neither she nor any of her family or friends really understood how traumatic this experience was for her.

**Insecure attachment**

It seemed clear from this history that Anne did not have the appropriate emotional resources to take care of her own needs during and after her mother's illness. We develop patterns of emotional self-regulation[ii] in our early childhood in response to our environment and the primary relationships on whom we depend. The quality or security of attachment we experience in our early years is pivotal to our development. Insecure attachment translates
into insufficient emotional self-regulation. ( Bowlby 1997; Schore 2003; Gerhard 2004; Le Doux 1996; Ogden et al. 2006; Siegel 1999).

Anne did not have much access to early memories, but we were able to ascertain some aspects of her early experience. For example she knew she had learned early to control her bodily functions – she walked early, was potty trained early and learned to read at the age of two. In order to achieve these levels of behavior and control, she learned to control her impulses and ignore her feelings long before she was developmentally ready to do so. I hypothesized to myself that her embodied mind would have had to organize itself around a fearful denial of her own impulses and needs and her thinking mind would

have developed prematurely, set defensively and punitively against her own embodied and emotional reality. Sue Gerhard captures this when she writes:

> "Children who have developed insecure strategies for dealing with their emotions cannot tolerate feelings and so cannot reflect on them. Their emotional habits for managing feelings kick in too quickly. Avoidantly attached children are likely to automatically slam on their emotional brakes when strong feelings start to arise, so that they don't have to be aware of feelings they don't know what to do with." (Gerhard 2004: 28-29).

The important point here is that Anne had become so efficient at 'slamming on her emotional brakes' that she no longer knew how to *feel* her distress. I had noticed for example that during the early stages of her therapy, whenever I made comments relating empathetically to her early childhood experiences, I met either incomprehension, criticism or was fended off with a humorous or sometimes cynical response. At best we might have a theoretical discussion about the conditions of her upbringing.

**Stress**

All of this indicated that Anne was not yet able to engage with her underlying issues and that we would need to deal with her current dilemmas first. Anne was able to recognize that she was under enormous stress. Stress is a very helpful and accurate concept to

introduce when working with psychosomatic conditions. The usual labels attached to psychosomatic complaints are that the cause is psychological or emotional. Clients understandably find this difficult to accept. The view that the symptoms are expressions of unresolved emotional arousal and refer to unconscious emotional material, may leave the client feeling criticized and undermined. It is indeed common for clients to feel that this implies failure on their behalf, that they are making this all up or are causing it. (Broom 1997; Sanders 1996).

The term stress, however, provides a more specific and far less stigmatizing explanation and tends to be more acceptable to the client. It also implies for most people that something can be done about it. Anne understood that she was under a great deal of stress dealing with her symptoms. She fought a desperate battle against her own body and could not find relief. The problem was that her body had become an enemy which she felt attacked by on a daily level. Anne was able to recognize that her coping strategies were not working, in fact she realized that the harder she tried to get rid of her symptoms the worse they became. She also understood rationally that the fear of her own body was likely to exacerbate her symptoms further.

I described the mechanisms of stress to her in very simple terms - that the stress response is activated when we feel threatened and that under normal circumstances, when the threat is over, the body switches into the relaxation response. However, when the experience of threat does not subside, the relaxation response is not activated and we

accumulate stress. We also acknowledged that this natural balance between stress and relaxation response might already have been undermined in her childhood and certainly during her mother's illness and we began to look at how she might be able to address this in her current situation.

I was hoping at this point that we might be able to build on Anne's existing coping strategies and resources. It felt crucial not to undermine Anne further by labeling her existing strategies as defensive and therefore wrong. I believe it is important to remember that defense mechanisms have the benign intent to protect and are deeply rooted within the client. In Anne's case her willpower and intellect were vital resources as they allowed Anne to make a commitment to learning new practical skills to manage her anxiety and distress. Having identified stress as an issue we could then begin to look at helping her develop skills for managing stress more appropriately. Over the following weeks Anne began to practice mindfulness and breathing regularly on a daily base - but I will come back to this later. I would like first to introduce another concept which provided reassurance and direction for Anne – trauma.

**Trauma**

Anne was quick to recognize that the circumstances of her mother's death had been traumatic. Identifying trauma as an underlying issue seemed to give Anne some sense of

identity and relief. The concept of trauma provided at least a logical hypothesis and more importantly, a hope that we might be able to do something about it. Trauma is a common undercurrent to psychosomatic distress and it is helpful to consider trauma specific clinical interventions in this work.[iii]

In this context the significance of working with the body is increasingly recognized. The necessary lowering of arousal levels can most effectively be achieved through skillful influence of the Limbic system, namely the ANS and the limbic brain. Developing the client's capacity to pay attention to body sensations and feelings is also vital before effective trauma processing can occur. Babette Rothschild (2000) talks about helping the client to learn how to stay safe and aware during the processing of traumatic material. Pat Ogden (2006) refers to the need to create "a window of opportunity", providing access to a safe space between hyper and hypo-arousal levels. It is within this calmer zone that unresolved emotional distress can be made conscious, felt and then integrated. (Rothschild 2000; Ogden et.al. 2006;

Levine 1997; Van der Kolk 1996).

**Working with breath**

In order to prepare the ground for processing the deeper distress underlying Anne's symptoms, it was my first priority to help her develop her capacity to pay attention to her embodied experience without fear or judgment. As is the case with many clients who suffer from psychosomatic conditions Anne's mechanisms for dissociation were very strong. I therefore decided to help Anne focus on her breath as a way to help her develop awareness of embodied experience.

I have found both breath awareness and conscious breathing techniques invaluable when working with psychosomatic conditions and indeed developmental trauma. Breath awareness refers to a simple monitoring of the breath without trying to influence it. This can help therapists and clients to become aware of habitual breathing patterns – and functions as a prerequisite for establishing mindful awareness.

Conscious breathing techniques refer to simple practical exercises where the client learns to expand their breathing capacity. A simple yet very effective technique for example is the 'calming breath'. Here we would extend the length of the exhalation, pause, and then let the body take the next in-breath. The active lengthening of the out-breath encourages a deeper and unforced in-breath which automatically sends messages to the limbic brain that all is safe. This evokes a parasympathetic response from the ANS which tends to manifest directly as a lowering of anxiety. It is important to remember, that any breath work undertaken in a psychotherapeutic context needs to build on an active inquiry into the client's direct

experience of breathing. This breath awareness informs any development of a regular daily breathing practice so that deeply ingrained breathing patterns can gently be influenced and readjusted. It is essential, however, that psychotherapists who would like to introduce such a direct body approach into their work have experienced and practiced breath awareness and breathing techniques for themselves. (Harvey 1988; Hendricks 1995; Farhi 1996; Swami Rama et al. 1998; Rosenberg 1998).

Anne understood that it would be desirable for her to learn to relax and engaged well with her breathing practice, which we carefully monitored. We realized quickly for example that she felt most safe and comfortable when practicing lying down and she reported after only a few weeks she was beginning to experience profound moments of calm. She also began to learn to observe not just her breath but also other body sensations and symptoms mindfully. I am using the term mindfulness here in it's basic definition, moment-by-moment awareness without judgment. After only a few weeks she was able for short periods of time to observe painful sensations in her body without fear. This was a big moment for both of us.

**A mindful approach to pain**

The acceptance of pain, both physical and emotional, is one of the most advanced and difficult processes to engage in. It implies learning to distinguish between pain and suffering, to accept that pain may be unavoidable but that suffering is determined by how

we relate to it. This is a crucial distinction to make with clients. Darlene Cohen, who suffered from rheumatoid arthritis for many years and used her meditation practice to help her manage her condition, illustrates this mindful attitude to pain when she writes:

> "At first my conscious life was all pain. Acknowledging the pain and its power eventually allowed me to explore my body fully and find there actually were experiences in my body besides the pain – here is pain, here is bending, here is breath, here is movement, here is the sun warming, here is unbearable fire, here is tightness – something different wherever I looked." (Darlene Cohen: 2000).

Here we see how through the strengthening of the 'observing' function, we can promote an experience of 'being here - now' as well as an acceptance of 'what is' and this makes it highly relevant for psychotherapy. Mindful awareness of embodied and felt experience is a long established aspect of body oriented psychotherapy and a natural resource for Chiron psychotherapists. Ron Kurtz's 'Hakomi Method' also incorporates mindfulness-based interventions and more recently Jon Kabat-Zin's 'Mindfulness-based Stress Reduction' programme has inspired a whole range of clinical applications and research trials establishing the effectiveness of mindfulness for a whole range of conditions both in a medical and psychotherapeutic context. (Kurtz: 1990; Kabbat-Zin: 1990, 2005; Germer et al.: 2005; Baer: 2003)

In this context I have found it hugely beneficial to introduce practical elements of mindfulness quite early on in the work and to teach the client that it is possible to pay

attention to their direct experience without any judgment and without feeling overwhelmed.

**Mindfulness of transference**

This mindful approach is also relevant for the inevitable transference issues which arise when working with psychosomatic distress. Anne had no difficulties practicing conscious breathing on her own and quickly developed her capacity to pay attention to her direct embodied experience for long stretches at a time. Things were dramatically different however when we were together. We discovered that my very presence or attention made her anxious and tense. She felt watched and controlled by me and kept disconnecting from her direct experience after just a few moments. For example, when we began to establish her breathing routine and I asked her to pay attention to her breath - to notice the movements accompanying her breathing, the length of her out and in breath, which parts of her chest or abdomen were moving - she reported that she found it hard to concentrate on these instructions. I encouraged her to describe what was happening in her mind and she told me that she had gone into thinking about the techniques and what purpose they served. Further explorations showed that she also had anxious thoughts about getting it right and critical thoughts about my instructions, my choice of words and the tone of my voice.

This helped us to engage in the exploration of the negative transference dynamics that were emerging. By acknowledging her direct experience, body, emotions and thinking mind without judging any of these unfolding processes we were able to build trust and safety in the therapeutic relationship. In the context of this chapter I will not be able to go into further depth on this important subject, but Shosi Asheri's chapter is an excellent exploration of relational issues and illustrates how important a mindful attitude is when working with transference issues.

When we introduce directive interventions such as breath work to help lower arousal levels, we need to be able to shift fluently between guidance and an open exploration of the emerging material, especially the transference. In Anne's case her tolerance to let me gain insights into her innermost, private experience grew and she became increasingly able to focus on and describe her direct experience. This was another crucial building block also for working towards the discovery of the hidden emotional meaning of her symptoms.

**Discovering new meaning through innate imaging**

Psychosomatic symptoms can also be viewed as metaphors (Landale, 2002). This is evidenced by the fact that most people when asked to describe their direct embodied experience will use metaphor to do so. Body sensations and symptoms can function as symbolic representations of unresolved emotional conflicts carried by the body. Of course

most of us will be familiar with ‘guided’ imagery techniques which are used to influence our limbic brain, our emotions and our overall physiology. However, there are limits to the benefits of ‘guided’ imagery because such images are introduced by the therapist. The point here is that in psychotherapy we are naturally more interested in the client’s innate imagination.

The way this relates to Anne is significant. Her thinking mind was acting as if it could come up with a clever solution to her problems, proposing new strategies at every turn - but in fact she was dissociated from her emotional experience. In her innate imagination she was dealing with unresolved feelings of fear, grief and hopelessness and she could not begin to consciously comprehend, let alone influence, her symptoms. Tuning into her innate imagery was a potent way of accessing her embodied emotional experience. For example, by focusing on a body sensation and asking her to describe it e.g. by its shape, colour, size or sound we were able to tap directly into her imagination and thus her unconscious.

Of course this way of working is not new. Freud in his early work engaged with innate imaging through free association as did Jung with his ‘active imagination’. Indeed before illustrating how innate imaging helped Anne to release some of the distress she was holding, I would like to quote Jung, who refers to these processes when he writes:

> “In the intensity of the emotional disturbance itself lies the value, the energy which he should have at his disposal in order to remedy the state of reduced adaptation. Nothing is achieved by repressing this state or devaluing it rationally. In order, therefore, to gain possession of the energy that is in the wrong place, he must make the emotional state the basis or starting point of the procedure. Fantasy must be allowed the freest possible play.” (Jung, quoted by Rossi 1993: 39).

So back to Anne, her decision to engage with a breathing and mindfulness routine had already allowed a less anxious awareness of her own body. She had an open psychological mind and had accepted the idea that psychosomatic symptoms might be an expression of unresolved emotional conflicts that she held in her body. When I further explained to her that by paying attention to her symptoms - without preconception - we might get those symptoms to reveal some of their meaning she was willing to explore this further.

In my experience it is important to pace this work so that the client can get used to the process and feel comfortable with it. Psychosomatic symptoms tend to come in clusters and the most pronounced symptoms are deeply entangled with anxiety and resistance. To try and engage too early with the underlying distress can be over challenging or even terrifying for the client. In Anne’s case her lower back pain was off limits in this respect - our tentative attempts at engaging with this pain had confirmed that her resistance was too strong – and we had therefore begun to work with secondary symptoms or sensations.

I would like to focus now on a breakthrough session that happened around three months into our work when Anne arrived at her session complaining about a persistent pain in the right side of her chest. She kept rubbing it as she spoke and was clearly agitated by it. I asked her if she felt ready to focus on these sensations and she agreed and decided to lie down. I said: “Take a moment to let your attention turn inward, notice your body lying down, feel how the weight of your body is being carried by the couch right now - notice also the steady rhythm of your breathing as your are lying here, supported by the couch”. I was intending with these instructions to help Anne make a state shift, to coax her away from her thinking, conceptualizing mind and help her instead to become more inward focused and receptive. I wanted to engage her limbic brain and my suggestions were aimed at making her feel more present and relaxed. By starting from a containing and calm position I was hoping that we were laying down an immediate memory trace to which we might need to resort later if the surfacing emotional conflict that I suspected was held deep within her symptoms became too distressing.

I then encouraged her to focus her attention on the sensations she was feeling in her chest. She said: “It is like something acidic, like acid burning just underneath my skin - the whole area feels so sensitive to touch - sometimes just having a shower sets it off. I don't feel it when I feel relaxed." And as she talked her hand was making circular movements, pressing down the right side of her chest. I was immediately struck by the term acidic, an evocative and disconcerting image. I am always on the look-out for

charged images like this as they can be entry points to deeper innate work. But this description emerged right at the beginning and I could detect fear in her voice as she talked about it. I was also instinctively guided by my own response to the term acidic, it is not something one would touch directly and without protection so I decided to take a more cautious approach.

I said: "As you keep focusing on this area could you describe the shape of it?" Anne responded immediately saying: "it's round". "Round" I echoed "and has it got a colour?" "Reddish - like when you've scraped off your skin. It's raw, like an inflammation. Acidic - coming up my oesophagus - like a very sharp bruise". Anne's unconscious had given us three evocative, visceral images - inflammation, acidic and bruise. Again I had to make an instinctive decision about which one to engage with. I decided to go with the last one and repeated: "Like a very sharp bruise. I wonder if you have a sense of what might have caused that bruise?" Anne: "It feels like something attached itself to me - like an alien. Mum used to describe her illness like a spider growing a web, invading her. It feels like webs inside my chest just underneath my skin, growing, turning into metastasis. I have an image of this metastasis, disguising itself as part of the bones, like a growth, like an egg/ half egg just sitting there".

Anne became quiet at this point, her attention was drawn inward. She seemed absorbed and I noticed that her breathing had become slow and shallow. I felt that I had to remain quiet in order not to disrupt her inner focus. Silences have different qualities. Silence can

feel withdrawn or detached, terrified, overwhelmed or angry. This silence felt potent. When Anne started speaking again, I could see that she was holding back her tears and it seemed to me that she was having to make a real effort to speak again: "When Mum was dying I wished for a while that I had the disease, so that I could fight it for her." She was crying now and after a few moments continued: "Her cancer felt like something intelligent like an alien which attaches itself to human beings".

I felt that the repeated metaphor of 'alien' needed to be explored more and I asked: "Could you describe this alien to me, what does it look like?" After a moment Anne replied: "It's like an octopus, a beast which wakes at times, something uncontrollable. I couldn't control it, could never really talk to Mum about her illness, so I remember visualizing it a lot. I could not talk to Mum so I just kept imagining it, that beastly creature which ate away at her." Anne was crying freely now and continued: "It showed itself, broke out of her skin, her skin full of metastasis, horrible smelly, decaying her. I was so frightened of her body - that this beast would animate her - I felt it reaching for my body - trying to attach itself to me also like I was linked to Mum's pain." We had reached a point where her embodied memories were surfacing spontaneously and I wanted to be sure that the recollection of these memories did not lead to re-traumatisation. My sense was that this was not the case. Anne's tears had a quality of grief and release and it appeared to me that she was sharing and shedding feelings which had burdened her for many years. I felt that this process was taking her into a deeper place of understanding.

The innate image of being linked to her mother's pain seemed to provide a poignant link with her own psychosomatic pain. I wanted to keep her focused on this and suggested: "Stay with this image of being linked to your Mum's pain. How would you describe this link?"

Anne: "It's like a mirror image - like the pain is in my body also - to a lesser degree but linking us together - her pain binding me to her, like I had to take this disease inside of me. I couldn't bear to just witness, not being able to do anything, so I kept imagining her pain - took her pain inside of me. I can cope with physical pain. I just don't know how to cope with all this emotional pain."

I felt deeply moved by the poignancy of this description. Her mother had been unable to acknowledge that she was dying and I suspected that this denial had communicated itself powerfully to the people around her leading the doctors to collude with this denial and leaving Anne to absorb and internalize her mother's fear and pain. But Anne's mother had been dead many years and Anne had a lot of good things happening in her life now. We had to understand what kept the pain link in place, why Anne still felt she had to carry her mother's pain. I asked: "And you keep on coping with so much physical pain, what purpose might this serve now?" Anne: "It helps to show how hurt I am. I don't want to get rid of it because I hold my Mum in there. I can then care for that pain."

Anne cried for a long while after this. I felt that this was a breakthrough point in our work. I had suspected that grief might be at the core of her symptoms because they had developed following her brothers' deaths. We had already recognized that the circumstances in which her mother died had been traumatic for Anne. But by helping her focus her awareness inward and encouraging her to follow the images which arose spontaneously from her deep embodied knowing, she discovered a hidden meaning to her somatic pain. In that moment her body-mind became whole, giving her a new sense of identity. She was able to *feel* the meaning of her symptoms. She realized that they belonged to her - formed part of her and she began to relate to them rather than trying to eradicate them.

> "When the attention is trained on the emotion in question – in particular, on the bodily experience of emotion – it gradually ceases to be experienced as a static and threatening entity and becomes, instead, a process that is defined by time as well as space. The technique of concentration permits the difficult emotion to be experienced as coming from ones own being, and it can then be understood and accepted rather than feared for its brute strength." (Epstein, 2001: 207).

**Conclusion**

After this breakthrough session Anne began to live with her symptoms differently. She seemed more accepting of her pain and discomfort and less anxious to get rid of it. She observed, some weeks later on, that her back pains had been less frequent and that when they came she saw them not with her previous sense of alarm but rather as a signal to slow down, rest and look after herself. A significant shift had occurred in only three months showing how much can be achieved even with complex attachment trauma issues when we work proactively with the resources of the embodied mind. Through her regular breathing and mindfulness practice, Anne had learned to pay attention to her body with significantly less anxiety and had begun to trust in her ability to manage her pain. Such resourcefulness can be a prerequisite to the safe processing of emotional charge inherent in psychosomatic distress.

However, I think it is also important that as therapists we are able to handle the delicate balance between structure and phenomenological emergence. In my own case I have found regular mindfulness meditation practice to be an invaluable resource in my psychotherapeutic practice. It helps me to pay attention simultaneously to the thoughts, feelings and embodied reality of the unfolding process.

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[i] The names and other identifying details have been changed to protect confidentiality - the imagery process described is accurate and published with Anne's permission.

[ii] See also Roz Carroll's and Kathryn Stauffer's chapters on the subject of self-regulation.

[iii] For a more detailed exploration of the subject I would like to refer readers to Morit Heitzler's chapter which offers a more indepth exploration.