The Body Remembers

CASEBOOK

Unifying Methods and Models in the Treatment of Trauma and PTSD

Babette Rothschild

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A NORTON PROFESSIONAL BOOK

In the broader definition of "family". . .

To my siblings:
Melanie, with whom I share genes,
and Jeanne, Bob, Peter, and Susan with whom I don't.
You each have a special place in my heart.

Contents

Introduction

The main goal of this book is to inspire psychotherapists working with traumatized individuals to learn as much as possible about theory, tools, and treatment so that they can be well-equipped in working with the unpredictability of trauma and the diverse needs of clients.

The cases presented here are not meant to provide instruction on how to do trauma therapy in a particular, or even several particular, ways. The aim is, instead, to promote the practice of learning and then applying a variety of methods in combinations tailored to the specific needs of each client.

A further goal is for therapists to learn to trust and use their own common sense as a complement to, and sometimes in lieu of, what they have been taught—to become able to recognize when interventions are not helping a client even when they "should," and when interventions that "should not" be helpful actually are.

ON COMMON SENSE

While I was living in Denmark, a window washer expressed interest in my work. When I told him what I did he asked, "What tools do you use for that?" It was an intriguing question. He wasn't askin me to give him a lecture on psychotherapeutic theory and method. His inquiry was much more basic and concrete; he was a workman and lived by his tools. I wanted to answer his question truthfully, bu it was a challenge to do so. After thinking about it for a minute, I replied, "I think my biggest tool is common sense—and that is something they did not teach me at the university." He looked me straigh in the eye and smiled, "Yes, we all need plenty of that in our work."

Common sense is probably the first, most important ingredient of safe trauma therapy—of makin any psychotherapy safe, for that matter. However, it is astonishing to realize that common sense is rarely mentioned, let alone taught, in courses on theory or treatment. My London friend and colleagu Michael Gavin can account for this omission, though: "Common sense," he likes to say, "isn't so terribly common."

There is a disturbing trend in psychotherapy, particularly in trauma therapy. Practitioners are becoming overly dependent on techniques that are learned and applied in a systematized manner, and are neglecting common sense and theory as aids to adapt these tools to the specific needs of individu clients. It is not that I find the protocols are lacking; actually, most of them are quite good. What is lacking too often, however, is thoughtful consideration before and during their application. When therapy methods are applied uniformly like a recipe, their potential for harm increases, no matter hov good they are.

Merriam-Webster's Collegiate Dictionary defines common sense as "sound and prudent but ofte unsophisticated judgement." For the window washer this might mean discarding a recommended cleaning product that does not perform as promised, putting off washing outer windows when rain is threatening, or avoiding a shaky ladder. Examples of applying common sense to trauma therapy include: laying aside or changing a technique or protocol that makes a client worse, putting off the approach to potentially distressing material until the client feels safe, adjusting the length of therapy to the client's needs, or using basic theory to create appropriate interventions.

ELIMINATING CLIENT BLAME

In 1969 Joseph Wolpe, founder of behavior therapy, cautioned his students to look for the cause of treatment failures within the application of their therapeutic methods, *not* within their clients. He went on to warn that failures of behavior therapy should not be attributed to client "resistance" or investment in "secondary gain." Wolpe believed that successful client change was the only justification for continuing with a particular method. In its absence, he advised, something different must be tried.

Our clients would greatly benefit from a broad application of Wolpe's wisdom to all schools of psychotherapy, and particularly to today's methods of trauma therapy. We are at a particularly difficult juncture as trauma practitioners: Competition for the superiority of one method or model over another is fierce. This trend puts clients in a difficult position: Should they prioritize choosing a method or is it more important to find a practitioner who is a good fit? Too many trauma therapists offer only one technique, which leads to questions regarding client commitment when that method fails. In such circumstances, the client can be hurt.

Even the most effective medicine cannot cure all patients. Witness the miracle of penicillin, which was an incredible boon to public health in the wake of World War II. However, penicillin is not a miracle drug for the patient who is allergic to it; symptoms range from the uncomfortable to the fatal.

Of course, in terms of life or death, psychological treatment methods are less risky than penicillin. But some clients suffer unnecessary distress, become retraumatized, or even decompensate from the use of methods that are advantageous to others. Preferably, the choice of method is never perfunctory but rather decided upon in consideration of and consultation with the client. And it is always a good idea to have other methods at hand in case the chosen method fails.

AN INSPIRING PROTOTYPE

In 1998 I witnessed a particularly poignant presentation at the annual meeting of the International Society of Traumatic Stress Studies. I had the privilege of being on the panel of the special symposium Issues in Creative and Body-Oriented Approaches to Trauma Treatment, chaired by David Read Johnson. The presentation of Betta de Boer-van der Kolk knocked my socks off. At that point in time, de Boer-van der Kolk, a clinical social worker who had not previously been exposed to body approaches, and her husband Bessel van der Kolk had been exploring applications of body psychotherapy to trauma treatment for several years. De Boer-van der Kolk had used herself, and her own trauma, to investigate the effectiveness of several methods. Those explorations became the theme of her paper "Integrating Body-Oriented Techniques in a Conventional Psychodynamically Oriented Clinical Practice." In it she described her personal experiences in resolving a serious car accident that had occurred in her youth and continued to affect her life into her early fifties. What was remarkable about her experience, and the retelling of it, was how clearly she was able to describe the relevant contributions from diverse therapies. The two methods from which she sought help clearly met different needs. The first, Al Pesso's psychomotor therapy, was instrumental in changing her feeling of isolation, helping her get back in touch with herself through repatterning the imprint of her family response following the trauma. The second, Peter Levine's somatic experiencing, helped her body to regain pretrauma homeostasis. It was clear from her presentation that either method alone, although helpful, would have left the resolution of that past event incomplete. The two therapies were consistent and compatible complements.

De Boer-van der Kolk's powerful presentation illustrated plainly how important it is for survivors of trauma to have access to multiple therapy methods and that no one method can address all issues. But what if this is not possible? Some clients do not have access to more than one therapist for economic reasons. For others, the risks of complications of transference are a deterrent. However,

there is nothing to hinder professionals from becoming trained in multiple methods in order to attend to the needs of their clients. And, when those obstacles do not exist, the road is open for therapists to cooperate with colleagues in team-treating individuals.

ORGANIZATION OF THE BOOK

This book is meant to encourage therapists to train in several treatment modalities so that treatment plans can be tailored to the needs and tastes of the client. The therapies illustrated here are not meant for replication, though some aspects may be useful and easy to learn. The case examples are presente to illustrate what is possible when different models are applied in varying combinations.

There are *many* more models available than are included in this volume. I have chosen the methods presented here because they are the ones with which I am most familiar. Absence of a particular method in no way implies negative criticism. Choosing therapy models to train in is a matter of taste and personal style. Those included in this book reflect my taste and my style. It is up t each psychotherapist to choose which ones suit his own.*

Each chapter spotlights one or more models that I have found useful in conjunction with the principles and interventions outlined in *The Body Remembers* (Rothschild, 2000). I have varied the writing style, interspersing chapters written as narratives and session-by-session descriptions with those that are primarily single-session transcripts. In general, therapy methods that are more containing (braking) are discussed before those that have the potential to be arousing (accelerating).

Many current therapies and interventions have foundations in earlier methods. I always try, albeit imperfectly, to give credit to the source of the methods and strategies discussed. I hope that readers and originators will forgive any mistakes or omissions, as none are intentional.

DISCLAIMER

It is no longer possible for me to begin a lecture, class, or book without repeating my standard disclaimer, in this case adapted to the particulars of this volume.

The book you are about to read comprises theory and speculation. Some of the therapy methods discussed herein have been formally studied, some have not. The client cases described do not prove the efficacy of a given method or methods; each is anecdotal. The opinions expressed are mine unles otherwise cited.

During a recent discussion with my personal physician, I challenged her recommendation for treatment. Instead of becoming offended, she remarked, “Well, you could be right. You know, today’ gospel is tomorrow’s heresy, and vice versa.” This wise response increased my confidence in her. Ha she insisted that she was the authority, or that there was only one right way, I would have looked for new doctor. In medicine this tenet is well-founded, as it is in science. It is also applicable to psychology. Diagnostic criteria change often—witness the evolution of the American Psychiatric Association’s *Diagnostic and Statistical Manual* (DSM), now in its fourth edition. Likewise, treatment methods come into vogue and fade into the background. There is nothing we can say works for sure and certainly nothing that works for everyone.

It is my hope that this book reflects the respect I have for the diverse practices, methods, models, opinions, and preferences of my colleagues and readers.

READER SELFCARE

One of my basic tenets is that trauma therapy does not have to be traumatizing. That philosophy extends to my lectures and trainings, and also to my writing.† Though it is impossible to eliminate al

risck, it is not fundamental for a book on trauma to be traumatizing to the reader.

What we have come to call *vicarious traumatization* is a risk for anyone exposed to the traumatic events of others. Vulnerability is not bounded by role. Volunteers, professionals, and even family and friends can be affected. The sequelae of trauma can be communicable in many ways, including through the media. The world over, individuals are affected by the trauma of others, through witnessing events on television, hearing reports on the radio, reading accounts in print media and books, and talking with others.

Just as survivors of trauma vary in their vulnerability to PTSD, so too do people, including psychotherapists, vary in their vulnerability to vicarious traumatization. Reading materials with descriptions of traumatic events, like those included here, pose a risk for vicarious traumatization, *depending on reader vulnerability*. Though attention has been paid to reducing risk as much as possible through careful editing, all risk cannot be eliminated.

Preventing Vicarious Trauma from Written Media

A good way to reduce the risk of falling victim to vicarious trauma while reading provocative materi is to pay attention to what is happening in your body, both physically and emotionally. Body awareness is your single best gauge of how something is affecting you. When hyperarousal occurs, it can be helpful to take a calming break. There are several reasons for this. First, it is not usually desirable to become upset from reading professional material. Taking breaks will make it possible to modulate the level of arousal. The second reason for taking breaks is that as hyperarousal increases, the activity of the hippocampus (a part of the brain associated with explicit memory and contextual thinking) becomes suppressed by the hormones released. This means that the higher the level of arousal, the less one is able to think clearly and digest or even remember the material one is reading. So, at the very least, it is a waste of time to read while hyperaroused, regardless of whether it causes long-term distress.

Next, it may be helpful to learn to avoid picturing the trauma situations in your mind's eye. Creating imagery—visual, auditory, and touch-, taste-, and smell-related—of traumatic events brings them much closer to the self. The more real a situation feels to you, the more risk there will be of vicarious traumatization.

Finally, listen to your internal dialogue. What you say to yourself does matter. How are you talking to yourself about what you are reading? Try to eschew language that increases your identification with the people and traumas you are reading about. The more you can separate yoursel from them, the less you will risk vicarious traumatic reactions.

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* *I have attempted to alternate the use of the pronouns he, she, him, her, his, and hers throughout the text.*

† *Although many professionals have heard stories much worse than those described in the cases in this book, some readers may have had little exposure to traumatic incidents. Those who know they are emotionally vulnerable to reading material on trauma (or those who worry about that possibility) may be helped by this section. Others may prefer to skip it.*

THEORY AND PRACTICE

Reviewing

The Body Remembers

To best utilize this casebook, the reader should be familiar with several concepts discussed in depth in *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment*. To that end, this chapter summarizes the subjects that are most relevant to the cases discussed herein. For a more complete discussion of these and other topics, the reader is referred to the original book.

DEFINING POSTTRAUMATIC STRESS DISORDER (PTSD)

The diagnostic category PTSD is relatively new in the annals of psychology. It first appeared in the third edition of the DSM (APA, 1980). The definition of the condition is unusual for two reasons. First, most categories of diagnosis in the DSM are symptom-dependent; clients displaying a certain number of particular symptoms qualify for a specific diagnosis. PTSD, on the other hand, is situation dependent. That is, there must be an identifiable event that qualifies as "traumatic" for the diagnosis of PTSD to apply. No matter the symptoms, if no event is pinpointed, the diagnosis cannot be made. Second, the original definition of PTSD depended upon majority rule, the "existence of a recognizabl stressor that would evoke significant symptoms of distress *in almost everyone"* (my emphasis; p. 238). In further editions of the DSM, that benchmark was dropped in favor of a standard that is broader and more reasonable.

As of this writing, the latest edition of the DSM (APA, 1994) recognizes that PTSD can result from exposure to events that are or are perceived as threatening to one's own life or limb, witnessing violence to or the violent death of another, or learning about violence to or the violent death of a relative or close associate. Further, this definition recognizes that children may suffer PTSD from "developmentally inappropriate sexual experiences without threatened or actual violence or [physica injury" (p. 424). In addition to experiencing a precipitating event, an individual qualifying for the diagnosis of PTSD must have a symptom profile that includes a reexperiencing of the causal event (often, but not always, in the form of intrusive images), avoidance of reminders of the event, and persistent symptoms of hyperarousal (sleep disturbance, concentration difficulties, hypervigilence, etc.; APA, 1994).

Distinguishing Stress, Traumatic Stress, PTS, and PTSD

The core of PTSD is *stress*, a condition identified by Hans Selye (1956). Stress results from any demand on the body, including demands of a positive nature such as aerobic exercise, competing on a TV game show, or having sex.

The most extreme stress is *traumatic stress,* which is a predictable consequence of exposure to traumatic incidents. It is traumatic stress that causes hyperarousal in the body's nervous system, making it possible to fight, flee, or freeze in response to threat. As a result, normal homeostasis is disturbed for a period of time. It is usual for symptoms to heighten and then gradually diminish over

period of hours, days, or even weeks. For example, after the events of September 11, 2001, many people around the world suffered from the hyperarousal of traumatic stress: nervousness, sleep disturbance, nightmares, changes in appetite, difficulty concentrating, etc. For even up to several weeks, these responses can be considered normal. But if symptoms prevent adequate functioning, a diagnosis of *acute stress disorder*—a short-term version of PTSD—may apply. What is not normal, however, is when symptoms of traumatic stress persist months or years after an event is over (hence the prefix "post").

When that happens, the term *post*traumatic stress (PTS) applies. PTS is not a disorder in itself. Further symptoms and dysfunction must be present to warrant a PSTD diagnosis. Many people function quite well with PTS, or what some call "subclinical PTSD." However, it is worth paying attention to PTS, as it appears it can accumulate and grow from exposure to multiple events and can reach a degree where symptoms would then qualify as a *disorder*. This possibility may help to explai how a seemingly well-functioning individual can suddenly suffer from PTSD following what appears on the surface, to be a minorly stressing event.

The clinical pictures of traumatic stress and PTS, or acute stress disorder and PTSD, may be indistinguishable. Those with traumatic stress from a recent event or PTS from a distant one may voice similar complaints while they continue to function in their daily lives. Likewise, someone suffering from acute stress disorder and someone with PTSD may exhibit the same symptoms and level of dysfunction. The determining factor within either of these pairings is the proximity of the precipitating traumatic event. However, the treatment of choice may differ greatly depending on whe the event occurred. The client suffering from a recent traumatic event will probably have different clinical needs than someone whose symptoms have been longstanding.

SOMATIC CONSEQUENCES OF TRAUMA

Although emotional response to any life event affects the body, trauma does so to the utmost. During traumatic incident the neurotransmitters released from the brain's limbic system signal an alarm to the autonomic nervous system (ANS). These hormones activate one of the branches, the sympathetic nervous system (SNS), to its most extreme arousal: preparation for fight and/or flight. Blood flows away from the skin and viscera and into the muscles for quick movement. Heartrate, respiration, and blood pressure all rise to give the muscles more oxygen. The eyes dilate to provide sharper distant sight. All of these elements of SNS arousal are necessary to respond to threat. When fight or flight ar not possible or have not been successful, the limbic system may further signal the ANS to *simultaneously* activate its other branch, the parasympathetic nervous system (PNS). The SNS continues its extreme arousal while the PNS freezes the action of the body—the muscles becoming either slack like a mouse caught by a cat or stiff like a deer caught in headlights (Gallup & Maser, 1977). What looks like paralysis or deadness to the outside observer, though, is misleading. The resulting internal strain of this extreme and simultaneous arousal is something akin to holding tight o the reins of a horse about to bolt out of control. Those who have experienced freezing commonly report that during such an episode time slows down and body sensations and emotions are numbed; it appears to be a kind of dissociation. As freezing only occurs when the individual's perception is that the threat is extreme and escape impossible, these reactions make perfect sense: People who have survived mauling by animals or falls from great heights report that this kind of dissociation reduces the physical pain and emotional terror during such experiences.

Successful fight or flight is usually enough to discharge the arousal of the SNS. Most people experiencing traumatic events do not end up in need of psychiatric intervention. However, the outcome with freezing can be quite different.

Though freezing is an excellent survival mechanism—the "dead" mouse wakes up and escapes after the cat has lost interest—it appears to exact a higher psychophysical price in the wake of a traumatic incident than the responses of fight and flight. Freezing during a traumatic event is a major predictor of who develops PTSD (Bremner et al., 1992; Classen, Koopman, & Spiegel, 1993). People who have frozen during traumatic incidents and survived appear to have greater difficulty coming to terms with their trauma. Somatic symptoms abound as the hyperarousal in both SNS and PNS persist chronically or are easily set in motion by internal or environmental triggers.

Because symptoms of anxiety and panic disorders also reflect ANS hyperarousal, it is easy to assume that they are caused by trauma. However, it is important to remember that PTS or PTSD cannot be assumed unless a causal event is identified. Still, many of the interventions and techniques used to reduce and contain hyperarousal with trauma clients are also useful with those affected by anxiety and panic.

PUTTING ON THE BRAKES

The first goal of any trauma therapy must be helping the client to contain and reduce hyperarousal. A useful metaphor for that process is *putting on the brakes.* When engaging anything that is powerful and potentially dangerous—whether it is a machine or an emotional process—knowing how to stop it is a prerequisite for safety. Like automobiles without well-functioning brakes, trauma processes can easily become overwhelming. When that is allowed to happen, retraumatization is the unfortunate result. Like a car speeding out of control with the accelerator pressed to the floor, "traumatic acceleration" is, simply, extreme, uncontrolled hyperarousal. Developing and using "trauma brakes" can prevent such out-of-control acceleration and the resulting retraumatization. Equipping a client with tools to slow down or stop traumatic acceleration will aid the therapy immensely. Clients who know they can stop or pull back from unpleasant memories have more courage to address them. Giving them control is an antidote to the out-of-control nature of traumatic events. Learning to apply the brakes is a necessary prerequisite for addressing traumatic memories. It is especially helpful for clients with whom direct work on traumatic material is either not possible or not advisable.

WHAT IS BODY MEMORY?

There are basically two major categories of memory: explicit and implicit. Explicit memory is conscious and requires language. It comprises concepts, facts, events, descriptions, and thoughts. Implicit memory, on the other hand, is unconscious. It is made up of emotions, sensations, movements, and automatic procedures. The terms "body memory" and "somatic memory" suggest th implicit.

The concept of body memory is easily misunderstood. It is not the body, per se, that holds a memory itself; the brain stores the memory. Body memory means, more precisely, an intercommunication between the brain and the body's nervous systems: autonomic, sensory, and somatic. When, for example, you remember how to ride a bicycle, it is not your muscles that actually remember the movement, though they are a crucial part of the process. The memory was laid down when you first learned to ride. At that time the sensory and somatic nerves in your leg's muscles and connective tissues communicated new patterns of movement (getting on and riding, how to balance, etc.) to your brain. It is there that those patterns were recorded and stored. Now, when it is time for you to hop on a bike, the same patterns are recalled from the brain, which sends messages back to those same tissues in your legs to replicate the same movements. Body memory is unconscious, implicit memory. It is automatic; you don't have to think about it. That is, for example, why once yo learn to ride a bicycle, type, or swim, you don't (usually) have to learn it ever again. Those patterns c

movement are stored forever in the brain.

There are those who argue that body memory is held in the muscles themselves, and even at a cellular level. While this could be true (though not yet proven) at least as far as movement is concerned, the memory that is stored in the brain is what is crucial. If that were not the case, those suffering from spinal injuries would still be able to move their limbs, walk, and so on. However, spinal cord injury interrupts communication between the brain and muscles resulting in paralysis—th muscles no longer receive instructions regarding how or when to contract and cause movement. In cases of limb amputation, memory of sensations and movements (phantom limb phenomena) continu to exist in the absence of the associated limb. This is because the somatic memory of the lost limb is stored in the brain.

The body also remembers traumatic events. Body sensations that constitute emotions (e.g., terror and physical states (e.g., pain or ANS arousal) and the patterns that make up movements (e.g., fight, flight, freeze) are all recorded in the brain. Sometimes the corresponding explicit elements—e.g., the facts of the situation, a description of the events—are simultaneously recorded; sometimes they are not.

TRAUMATIC MEMORY VS. MEMORY OF OTHER EVENTS

The Amygdala and Hippocampus

Within the limbic system of the brain are two related areas that are central in memory storage: the *hippocampus* and the *amygdala*. The last few years have produced a growing body of research that indicates these two parts of the brain are essentially involved in response to, and memory of, traumatic events (Nadel & Jacobs, 1996; Post et al., 1998; van der Kolk, 1994). It is believed that the amygdala's job is to register highly charged emotions, such as terror and horror, along with the body sensations that identify them. The amygdala becomes very active when there is a traumatic threat. This is the part of the brain that signals the survival alarm that eventually leads to the ANS preparing the body for fight, flight, or freeze. Memories of terror and horror, including concomitant body sensations and protective or defensive movements, are not stored in the amygdala but must be processed through the amygdala in order to be recorded as implicit memories in the brain's cortex.

The hippocampus, on the other hand, is necessary to the eventual storage of information that help us make cognitive sense of our memories—for example, to contextualize them in time and space. Th hippocampus helps to put our memories into their proper perspective and slot in our life's timeline. As with the amygdala, memory is not stored in the hippocampus, but the information must be processed through it before being recorded as explicit memory in the cortex.

The importance of the hippocampus in traumatic memory becomes clear when one looks at what can happen to memory while recording a traumatic event. When the arousal in the ANS becomes very high, the activity of the hippocampus can be suppressed by the wealth of stress hormones released. When that happens, its usual function of lending context to a memory is not possible. The result may be that the traumatic event is prevented from becoming a "memory" in the usual sense of the word: A piece of information about oneself that lies clearly in one's past. Instead, elements of the past experience are unable to anchor in time. They seem to float freely, often invading the present. In the absence of hippocampal activity, memories of unresolved traumatic incidents may remain in the implicit memory system alone. There images, sensations, and emotions can all be provoked, but without engagement of the explicit memory system, they cannot be narrated (cohesively recounted) o understood. It is this mechanism that is behind the PTSD symptom of *flashback*—episodes of relivin the trauma as if it is happening now.

Also affecting the memory of traumatic events as mediated by the hippocampus is the ability to think clearly during the event. When stress is combined with fear or anxiety, the ability to think clearly can be compromised. A common, if trivial, example is game show contestants, who often comment that it is much easier to answer correctly when watching the show from home than it is while in the studio.

The ability to make sense of traumatic events at the time of their occurrence is often reduced because of the combination of extreme fear and stress escalated to hyperarousal. This phenomenon further supports the idea that trauma therapy is best conducted with the brakes on. Keeping the level of hyperarousal low helps ensure that the client will be able to think, integrate, and make sense of what is processed in therapy. When a client is so afraid that he is not able to make sense of what happened, or, for that matter, what is occurring at any moment in the therapy setting, it is a sure sign that somewhere in him, the stress level is too high and it is time to put on the brakes.

Dissociated Elements of Experience

Memory of any event is made up of the components of that experience. Peter Levine's (1992) SIBAM model is a useful way to conceptualize this. The model was developed in an effort to understand dissociation of memory. Levine identifies five major elements—sensations, images, behaviors, affects, and meanings—common to any experience. Usual memories of nontraumatic events hold all of these elements intact. Recall triggered by one of the elements usually elicits the others. This is a common experience: Remember the last time you were reminded of a pleasant time in your life by th smell from a bakery or a particular song. This kind of memory recall happens from time to time to nearly everyone.

Memory of traumatic events, however, can be different. Though sometimes a traumatic event is remembered in its entirety, it is more common for it to be remembered piecemeal and dissociated. That is, some of the elements appear to be missing while others are highlighted. One client might hav visual flashbacks of an event, indicating that she remembers images and has emotional reactions to them (terror), but lacks awareness of body sensations and the narrative (meaning) that can make sens of the flashbacks. A child might reenact his trauma during play, indicating that behaviors are remembered, but have no recall in images or of facts that could tell where or why his behaviors originated.

The most troublesome traumatic memories are those that involve body sensations and little else. In such cases, the body sensations associated to the traumatic memory are intact, but the other elements, particularly the cognitive aspects—i.e., facts, narrative, time and space context (mediated by the hippocampus)—that could help the individual to make sense of the memories appear lost. Working with implicit, trauma-based sensations in the absence of a trauma narrative can be difficult. The explicit memory may or may not emerge. In such cases it is sometimes necessary to find ways to ease the symptoms and/or increase their containment, as their origin might never be known. At the same time, reducing hyperarousal as a goal in itself sometimes makes it possible to recall an otherwise lost event.

EVALUATING CLIENTS FOR TRAUMA THERAPY

It is extremely important to remember that *not all clients benefit from work with specific traumatic memories,* and some even become worse. Distinguishing who is a candidate for therapy that is primarily containing—e.g., putting on the brakes, (re)developing resources, building life skills—and who can manage a therapy that increases hyperarousal—presses on the accelerator by addressing

traumatic memories with various methods—is crucial to safe and successful trauma therapy.

A complete case history is always necessary to assess any new client. It is tempting to skip this step with those who come to work specifically on a single trauma, but that is inadvisable. Restricting attention only to information about a single event is like looking at a two-dimensional picture—there is much unknown and unseen that could land both client and therapist in trouble. A much better idea to create a multidimensional picture of each client. It is particularly important to evaluate current and past resources, attachment issues, physical and mental health history, and drug and alcohol history and current usage. Many therapists construct genograms (McGoldrick, Gerson, & Shellenberger, 1999) or use instruments to evaluate current functioning, such as the Impact of Events Scale (Weiss, 1996), Somatoform Dissociation Questionnaire (SDQ-20) (Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1996), and the Dissociative Experiences Scale (DES) (Carlson, 1996). Finding the assessment tools and methods that give you the information needed to enhance your work is a matter of clinical judgment. Those mentioned here are examples—not necessarily recommendations. Find what works best for you and the types of clients you work with.

Client Types

Lenore Terr made the first proposal for categorizing trauma clients: Her definition of Type I refers to clients who have experienced a single traumatic event; Type II are those who have been repeatedly traumatized (Terr, 1994). Though a good beginning, it is helpful to further break down Type II clients into subgroups:

Type IIA clients are those who have experienced multiple traumas but are able to separate the individual traumatic events from each other. This type of client can speak about a single trauma at a time and can, therefore, address one at a time. Usually these clients have an early history that included stability and healthy attachment. Thus, they have many resources, including resilience.

Type IIB individuals are so overwhelmed with multiple traumas that they are unable to separate one traumatic event from the others. Type IIB clients begin talking about one trauma but quickly find links to others. The stress level is so high that making sense of any or all of the events becomes impossible—they appear (and may be) linked and interconnected.

Type IIB(R) clients have a stable background, but the complexity of traumatic experiences is so overwhelming that they can no longer maintain resilience.

Type IIB(nR) clients have an unstable background bereft of resources for resilience. Features of borderline personality disorder are often seen in these clients. Those with dissociative identity disorder represent the extreme of this type.

Evaluating a trauma client's type can help give clues to therapeutic direction and choice of method. For example, Type I and Type IIA individuals usually require less attention to the therapeutic relationship and have less tendency to develop an intense transference to the therapist. They can often move quickly to working directly with the traumatic incident(s) that brought them to therapy.

For Type IIB clients, on the other hand, resource (re)building through the therapeutic relationship is a prerequisite to addressing traumatic memories directly. For those with stable, resource rich, backgrounds, reacquainting resources is in order. But with clients who have had little opportunity for resource-building, it is necessary to build many resources from scratch. For the Type IIB(nR) client, working on the therapeutic relationship is the most important, constituting a significant part, if not all of the therapy.

Integration and resolution of traumatic experiences in both mind and body is the goal of trauma therapy. To accomplish that, all of the above principles need to be gathered and applied as treatment

interventions regardless of the methods used. Integrated trauma therapy is the topic of the next chapter.

CHAPTER TWO

Integrated Trauma Therapy:

PRINCIPLES, METHODS, AND MODELS

Nearly every model of psychotherapy, body psychotherapy, and trauma therapy will be helpful if applied to the appropriate client at the proper time, with common sense, patience, and attention to client feedback. Our clients are our best experts on what works for them: If we ask the right question they will be able to tell us during and after each session and course of treatment what works for them and what does not. No one method is one-size-fits-all; accepting that fact—recognizing that there are always limitations when dealing with individuals who each have widely varied needs—is an example of common sense.

TEN FOUNDATIONS FOR SAFE TRAUMA THERAPY

The ten foundations of safe trauma therapy, first printed in *The Body Remembers,* form the basis for this casebook. They are included here with additional commentary:

1. *First and foremost: Establish safety for the client within and outside the therapy.*
   Judith Herman first taught us the importance of this principle in *Trauma and Recovery* (1992). Working with trauma involves helping the client loosen the defenses that have been used to cope with trauma. If the client is not living in a safe situation, or if the therapy situation does not feel safe, then a loosening of those defenses can lead to decompensation or even increase vulnerability to further harm.

2. *Develop good contact between therapist and client as a prerequisite to addressing traumatic memories or applying any techniques—even if that takes months or years.*
   Research consistently indicates that the therapeutic relationship is one of the most powerful factors affecting the outcome of psychotherapy. This also applies to trauma therapy. Without a therapeutic alliance, the client will not feel safe to address the terror of her past. Of course, there will be marked differences in how central a role the therapeutic relationship plays in individual therapy, but a solid alliance is always a necessary part.

3. *Client and therapist must be confident in applying the "brake" before they use the "accelerator."*
   As with an automobile, safe therapy requires that you know how to stop a trauma process befor you set it in motion or accelerate it. Working with trauma can be uncertain and potentially volatile You never really know how a client will react to an intervention, or, for that matter, to a simple question, the color of your shirt, or the smell of your coffee. One of the features of PTSD is that traumatic memory can be easily triggered. When that happens, hyperarousal accelerates out of control, causing intense physical symptoms and/or flashbacks. Until triggers are identified, they ar unpredictable—literally anything can be a trigger. In order for clients to feel safe in life and also i therapy, they need to be equipped with tools to help them contain reactions to therapy and triggers and to halt the out-of-control acceleration of hyperarousal. Being able to "put on the brakes" will

aid clients in their daily life, as well as give them courage to address difficult issues. Once clients know where the brake is, they are in control of rather than at the mercy of, their process.

4. *Identify and build on the client's internal and external resources.*

In general, resources mediate the negative effects of trauma. Resources are like assets—the more you have, the better off you are. Helping clients to identify the resources they already posses and develop the ones they lack is necessary to safe trauma therapy. Functional resources such as adequate locks, physical resources such as strength or coordination, psychological resources such a a sense of humor and defense mechanisms, interpersonal resources such as friendships, family, an pets, and spiritual resources including belief systems and communing with nature will all help in mediating trauma.

5. *Regard defenses as resources. Never "get rid of" coping strategies/defenses; instead, create more choices.*

Defense mechanisms are strategies for dealing with adversity. They are like old, dependable friends, helping us to deal with stress and getting us through hard times. The problem with them is that they tend to be one-sided, allowing only one choice for action. However, getting rid of a client's defenses doesn't solve problems and can actually increase them. Eliminating defenses rob clients of old friends and can leave them without coping strategies. A better alternative is to create additional, more adaptive defenses—new friends—so there are more choices of response. For example, instead of stopping a tendency to withdraw, pay attention to when it might be the best strategy, and simultaneously build skills for engaging with others. That way the client can decide for himself when it is best to be in the company of others and when it is better to be alone.

6. *View the trauma system as a "pressure cooker." Always work to reduce—never to increase—the pressure.*

Provocation is never a useful therapeutic strategy for those with PTSD. These individuals are already at the edge of how much they can handle. To further provoke a PTSD client's fragile syste through confrontation or provocative interventions can further damage her; the possibility for retraumatization when using such interventions is great. It is much better to reduce pressure while increasing resources. That will enhance the possibility of opening up a fragile system without explosion (or decompensation).

7. *Adapt the therapy to the client, rather than expecting the client to adapt to the therapy. This requires that the therapist be familiar with several theory and treatment models.*

The trauma therapist who only has one therapy method to offer his clients puts them in jeopard —no matter how great the model is. Many methods use techniques that are unappealing to some clients; others require ways of thinking that may be foreign. With only one kind of therapy on han the clients who, for whatever reason, do not fit with that method are at risk of additional harm through feelings of helplessness and failure.

8. *Have a broad knowledge of theory—both psychology and physiology of trauma and PTSD. This reduces errors and allows the therapist to create techniques tailored to a particular client's needs*

Being versed in only one school of theory is like only being able to bake a cake from one kind cake mix. A more tasty alternative is to keep a wide range of recipes and ingredients on hand. This makes it possible to create and choose the combination that is most appropriate at a particular tim

Knowledge is power. While no therapist can help all clients, the therapist who is familiar with

variety of theories has many clinical possibilities open to her. She then has the potential to create interventions uniquely suited to an individual client for a particular circumstance.

9. *Regard the client with his/her individual differences, and do not judge for noncompliance or for th failure of an intervention. Never expect one intervention to have the same result with two clients.*

When a medication fails to cure a patient it must be assumed that the correct one has not yet been found. The same applies to interventions or methods that fail to work with clients. The therapist must continue to look for or create an intervention or method that might succeed. It is important to avoid blaming the client by habitually thinking in terms of "resistance" or "secondary gain." Those terms imply that the client is impeding the success of the therapy—consciously or unconsciously—and that if he cooperated all would go well.

No two people are alike. A single method can work for many individuals, but it is demeaning t clients to assume that that will always be the case.

0. *The therapist must be prepared at times—or even for a whole course of therapy—to put aside any and all techniques and just talk with the client.*

It is great to have a broad collection of tools to work with in helping clients. However, there ar occasions when the best thing we can offer clients is ourselves. I look back with embarrassment or situations in my early professional years when a client came to therapy with a pressing upset. Sometimes I was so quick to be clever with my tools that I would completely miss what was needed, often something as simple as listening. We do our clients a great injustice if we can only relate to them through our methods. For all clients sometimes and some clients all the time, the be therapy is just simple, unadulterated, human contact.

CHOOSING EFFECTIVE METHODS FOR CLIENTS

Outcome studies are valuable in that they offer basic guidelines, but they are limited to only a few of the available methods and can be misleading if taken at face value or viewed singly. An overview of research studies for trauma therapies reveals conflicting results, as many of the studies showing efficacy are disputed by subsequent studies and vice versa.

A recent article by Westen and Morrison (2001) casts light on both the advantages and limitation of outcome studies. They raise many important issues that need to be addressed if we are to better scientific research. One of their major points is particularly relevant to the topic of this book: the importance of distinguishing between *unsupported* treatment models and *untested* ones. The former have been shown to be deficient in some way; the latter have yet to be evaluated. That a method has not been proven in no way implies that it is flawed or unusable.

In the trauma field we have very few methods that have been studied and judged to be effective. We have many more methods that are still untested. That does not mean that we cannot use them, onl that we need to apply them (as well as those that have been evaluated, for that matter) with caution, evaluating them as we go.

So how is one to choose an effective treatment for a particular client in the face of confusing outcome evidence for some methods and a lack of statistical evidence for others? The most obvious answer to that question involves common sense: *Ask your client.*

Rather than depending on outcome studies, help your clients to figure out for themselves what works best for *them.* Teach self-awareness, body awareness, and emotional awareness. Help your clients to ask questions such as: "When we are working in this way do I feel more calm? Do I feel more present? Is my life working better? Am I more resilient?" If the answer to those questions is primarily "yes," the direction you are going and the methods you are using are working well.

However, if your clients are answering “yes” to: “Am I feeling more unstable, more decompensated, more spacy, less productive, or having more difficulty concentrating?” you need to try a different tack. In this way you both can evaluate *together* what works best.

Basically, the more models and approaches you have integrated in your practice, the more you ca offer your clients. Begin by experimenting with one that seems promising for and/or appeals to your client, and then evaluate it. If it works well, continue with it; if it doesn’t, try another. I often describ two or three methods to my clients and let them decide which seems best to try first. Make sure not t offer too many alternatives at once, as that can be overwhelming.

Another advantage of including clients in the decision-making process is that it gives them a greater sense of control over the therapy. Remember, control is *always* compromised in trauma—trauma does not happen when one is in control—so the more you can give your trauma client a greate degree of control, the better.

CHOOSING A THERAPIST VS. CHOOSING A THERAPY

Every psychotherapist understands the importance of the therapeutic relationship. One of the risks of the current trend of competition among schools of trauma therapy is that the therapeutic relationship can suffer. With the emphasis on method, the relationship takes a back seat. This may work for some Type I and Type IIA clients. Yet for Type IIB clients—those for whom the therapeutic relationship is most important—the result can be devastating.

The importance of the contact between therapist and client is also ignored by the trend in manage care to limit the number of allowed psychotherapy sessions to sometimes as few as two. This is unfortunate, as it is the client who loses. In order to delve into difficult issues, expose vulnerable emotions, and tell secrets, a level of trust must be built. Moreover, when sessions are limited, the emphasis may be on resolving a traumatic situation or memory that a client is ill-equipped to address Again, it is Type IIB clients who are most negatively affected by the limitations imposed by some managed care companies.

Overview of Theory and Treatment Models Applied in this Book

"There are many ways and means of practicing psychotherapy. All that lead to recovery are good."

—SIGMUND FREUD (1953)

This chapter contains a brief overview of the methods and theories applied in this book. Some of them are rooted in general psychotherapy and some are specific to work with trauma. I have chosen them because they are the methods with which I am most familiar. However, just about any theoretic model and method of psychotherapy or body psychotherapy can be adapted for work with trauma when it is combined with adequate amounts of common sense and a basic theory of trauma's effect o the body and mind.

SOMATIC TRAUMA THERAPY

Somatic trauma therapy is what I call the work I do, teach, and write about. I never set out to create a new model. My primary concern has always been to make trauma therapy safer. Somatic trauma therapy is an integration of the theories and models I have learned, peppered with occasional bits of original thinking and a liberal amount of common sense. Every therapy in this book is consistent wit somatic trauma therapy, as are the exercises and cases in *The Body Remembers*. The basis for somati trauma therapy is my concept of "putting on the brakes"—before and during work with traumatic memories.

BODY PSYCHOTHERAPY

There are many types of body psychotherapy, just as there are many types of psychotherapy. To identify oneself as a body psychotherapist, one must in some way consider the body as part of the psychotherapy process. Most body psychotherapists believe that integration of mind, body, and emotions is the major goal of therapy. However, how this goal is approached can vary widely. There are those who sometimes touch, hold, or otherwise physically comfort a client, and those whose majo goal is emotional release. For a long time there has been a growing trend in the field of body psychotherapy to pay greater attention to the intricate function of the body, including the nervous system, muscular anatomy, visceral systems, etc., and the synergy between these systems and the mind.

Examples of body psychotherapies in this casebook are: somatic trauma therapy, Levine's SIBAM model, and the bodynamic running technique. Sometimes eye movement desensitization and reprocessing (EMDR) is also placed in this category because of the use of eye movements and the inclusion of body awareness in its protocol, but as of this writing, the EMDR Institute has no relationship to any body psychotherapy organizations.

PSYCHODYNAMIC PSYCHOTHERAPY

Psychodynamic psychotherapy is based on the idea that behavior is influenced by unconscious

motives and feeling states. Gaining insight into this unconscious material is essential to change. It is the principle underlying psychoanalysis and many current psychotherapies, including many body psychotherapies. The major technique employed in psychodynamic psychotherapy is verbalization of the thoughts, feelings, and memories the client has—putting them on the table, so to speak—so that they can be looked at. Catharsis is believed to help this process by relieving the pressure of emotion and clearing the mind for more rational thought. The importance of transference and countertransference is also emphasized in psychodynamic psychotherapy.

In the field of trauma therapy we have many old and new therapeutic tools at our disposal; for some clients, the basics of psychodynamic psychotherapy are just right.

TRANSACTIONAL ANALYSIS (TA)

TA was developed in the 1950s by the psychiatrist Eric Berne (1961). As its name implies, it involve the analysis of interpersonal and intrapersonal communication. Adherents of Berne's TA coined the now-common terms *inner child* and *adult egostate.* The theory and concepts of TA were influential i the development of ego state therapy (Watkins, 1993), which is currently used in conjunction with hypnosis for the treatment of dissociative disorders (Phillips & Frederick, 1995). The emphasis in TA is on the interaction (transactions) among the *parent, adult,* and *child egostates,* whether between people or intrapsychically.

Particularly helpful in trauma therapy is the TA concept of *redecision* (Goulding & Goulding, 1979), where the client identifies decisions made during stressful times or traumatic events. Once decisions are uncovered, they can be looked at and "redecided" when appropriate.

The goal in using TA in trauma therapy is to develop a better inner relationship and dialogue, which furthers healthy adaptation and growth.

GESTALT THERAPY

Gestalt therapy was founded in the 1940s by the psychoanalyst Fredrik S. Perls. It was revolutionary the time as it focused on the here and now, rather than seeking historical roots to personal problems (Perls, 1942). Practitioners of Gestalt therapy are interested in monitoring changes in all aspects of awareness, including body awareness, though Gestalt is not considered a body psychotherapy.

The most widely known aspect of gestalt therapy is the "empty chair" technique, popularized in films of Perls's work at Esalen Institute in the 1960s. Contemporary use of this technique is common among psychotherapists of many disciplines, as it is useful for making internal conflicts and dialogu concrete.

In trauma therapy, the gestalt therapy empty chair technique can be useful for projecting inner conflicts outward where they can be heard, viewed, assessed, and, hopefully, changed. It is a useful adjunct to transactional analysis in aiding the dialogue between egostates.

COGNITIVE BEHAVIORAL THERAPY (CBT)

CBT is a composite of several methods, all based on the principle that how we think influences how we feel and behave. The major goal of CBT is to change how the client thinks about his problem, whatever that may be: trauma, phobia, conflict at work, etc. Then, it is believed, changes in emotion and behavior will result.

Principles from CBT lie at the heart of most currently available trauma therapies. Actually, much counseling and psychotherapy has roots in one or more aspects of CBT, including cognitive therapy, assertiveness training, and relaxation training (Foa, Keane, & Friedman, 2000). Systematic