Working with Severe Trauma: Using Safe and Effective Body-Oriented Approaches During the Initial Phase

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Introduction

> "It is true that at the core of our traumatized and neglected patients' disorganization is the problem that they cannot analyze what is going on when they re-experience the physical sensations of past trauma, but that these sensations just produce intense emotions without being able to modulate them, then our therapy needs to consist of helping people to stay in their bodies and to understand these bodily sensations. And that is certainly not something that nay of the traditional psychotherapies, which we have all been taught, help people to do very well."
>
> Bessel van der Kolk (1998)

Body-oriented therapy does not receive the recognition it well merits, as an effective avenue for the healing of trauma. It appears that many of the so-called "evidence-based" trauma treatments gain their popularity and legitimacy as a result of the findings that have been made available via scientific research. Unfortunately, few studies on the efficacy of body-oriented treatment have been funded and/or supported within the mainstream mental health system. This has been of great detriment to a great many people who suffer from the impact of trauma, who access therapy services that do not adequately meet their very specific needs. Rothschild (2000) has this to say about the new tools offered in her book *The Body Remembers: the Psychophysiology of Trauma and Trauma Treatment*:

> "Yes, despite a plethora of study and writing on the neurobiology and psychobiology of stress, trauma, and PTSD, the psychotherapist has until now had few tools for healing the traumatized body as well as the traumatized mind. Attention directed at the body has tended to focus on the distressing symptoms of PTSD, the resulting problems of adaptation, and possible pharmacological interventions. Using the body itself as a possible resource in the treatment of trauma has rarely been explored. Somatic memory has been named as a phenomenon (van der Kolk, 1994), but few scientifically supported theories and strategies for identifying it, containing it, and making use of it in the therapeutic process, have emerged." (Rothschild, 2000,, p.5)

Over the years I have worked with many clients who are haunted by the disturbing post-traumatic stress symptoms they constantly experience at a body level. Some organizations I have worked for have taught me the value of using breath, relaxation, and grounding in the present moment, all techniques to assist clients to manage their symptom. With no specialized training in these techniques, I struggled for years trying to familiarize myself well enough with them so that I could teach them to my clients for symptom management, in and

out of session. My sense was that I needed to delve deeper into understanding the value of meditation, so I decided to pursue learning and practicing the mindfulness meditation approach so well known in the East.

Indeed, by connecting to myself via my bodily sensations, this practice has taught me the power and wisdom of accepting the present moment, and patiently waiting for uncomfortable and/or painful emotions, thoughts, and physical sensations to subside, as they inevitably always do with the ebb and flow of life. When I brought mindfulness into my professional practice, many of my clients reported feeling some relief and/or peace by using and/or reading books on the benefits of mindfulness. Clients also awakened to feelings and sensations in their bodies that they did not realize existed. Through mindfulness clients were also able to non-judgmentally observe their thoughts and thought distortions, and the impact of these thoughts on their emotions and physical sensations. The majority of clients I worked with then had suffered severe trauma, and often they reported that the mindfulness meditation and grounding exercises were of great use to them.

This indicated to me that there must exists a deeper, more expansive, and intuitive level of healing work for clients in devastating and hopeless states, inspiring me to pursue body-oriented therapeutic/healing training. Being serious about deeply connecting to my innate ability to become a more effective therapist/healer, I embarked on an intensive training program that has to experience, first hand, the power of such healing. The four-year training program in bioenergetics and energy healing at the Integral Healing Centre of Toronto is now coming to an end and this paper is both a required part of the evaluation criteria and my personal mission to enrich my knowledge of body-oriented therapeutic approaches in the treatment of severe trauma. This thesis is grounded in the bioenergetics, energy, and mindfulness approaches that have so deeply impacted on my personal and professional growth. It is intended to further my understanding, and in doing so hopefully that of other therapists and students, of these three key body-oriented practices can be complimented by other body-oriented therapeutic approaches. New approaches that will be reviewed include somatic, sensorimotor, and somatic experiencing therapeutic modalities, all of them having useful theoretical and practice-based information to share, pertaining to the safe and effective treatment of severely traumatized clients.

In my opinion, despite the commonalities and overlap in their philosophical and practical orientations, each body-oriented therapeutic avenue mentioned in this paper, in one way or another, provides an extremely valuable, innovative, and unique contribution to the field of trauma. Furthermore, I believe that the commonalities, to varying degrees, stem from a profound understanding and faith in the true capacity of the body and mind to heal itself through the power of deep connection with oneself, others, and the wisdom of all life.

Levine (1997) speaks to the wisdom inherent in body-oriented trauma work:

> "The roots of trauma lie in our instinctual physiologies. As a result, it is through our bodies, as well as our minds, that we discover the key to its healing. Each of us must find those roots, realizing that we have a choice—perhaps one of the greatest in our lives. The healing of trauma is a natural process that can be accessed through an inner awareness of the body. It does not require years of psychological therapy, or that memories be repeatedly dredged up and expunged from the unconscious. We will see that the endless search for and retrieval of so-called "traumatic memories" can often interfere with the organism's innate wisdom to heal"

For over two decades, I have been traveling the conscious and dedicated path towards becoming a therapist/healer. During that time I benefited enormously from the challenges, teachings and rewards associated with being counsellor/therapist to hundreds of dynamic individuals, a great majority having experienced varying degrees of trauma at various stages of life. Much of this experience has been within the public sector, that is, within what is known as the non-profit public mental health care system. I have always been in awe of how these clients seem to draw on every resource available to them to survive such hideous crimes and unfathomable realities. Sadly, I have also witnessed many clients with histories of inter-generational trauma marked by extreme neglect and various forms of cruelty and abuse, fall through the cracks of this system as they sit on lengthy waiting lists for mental health services while desperately calling on their very limited, and often primitive, internal and external resources.

Their ability to cope with, and survive, the chronic adverse effects of their trauma with sporadic time-limited professional support, is remarkable to say the least. Unfortunately, I have witnessed many clients with compounded socio-economic barriers (these clients are rarely afforded the opportunity of accessing low-cost or free ongoing therapy services) buckle under the overwhelming pressures inherent in their internal and external day-to-day existence. The consequences of this range from experiencing serious set-backs marked by disintegration, decompensation, suicidality and various forms of self-harm, to the development of serious mental health disorders. This situation is even more serious if one considers high number of infants, children, adolescents, and adults fall who pray to the violence perpetrated by survivors of trauma who have not resolved their own traumas.

My motivation and strong will to become an effective therapist/healer with clients struggling with any and all issues is great. However, I am very aware that in my path clients suffering from complications associated with the most horrifying of traumatic histories have touched me deeply, and so I view the opportunity of writing this paper as a necessary part of preparing myself to fulfill my soul's mission.

This paper strives to present aspects of my learning process as derived from, first and foremost, the face-to-face encounters in my work with clients suffering from the debilitating impact of complex post-traumatic stress disorder (PTSD). The paper will aim to present a comprehensive breakdown of how different therapeutic approaches that utilize body-oriented work, and acknowledge the central concept of energy, can be utilized complimentarily to assist the therapist formulate a treatment plan to meet the individual needs of traumatized clients. While acknowledging marked differences between some of these approaches, I will focus attention on presenting commonalities in order to demonstrate the possibility of incorporating any one of these approaches into one's practice.

My own training in body and energy haling work is grounded in bioenergetics, energy healing, and mindfulness practice. However, I have also found some of the insights provided by newer somatic-oriented therapies based on solid understanding of the psychophysiology of the brain and nervous system to be of great assistance to me and my clients. My own experience leads me to believe that what the newer approaches do best is to focus the stabilization, resource building, and symptom management work in a manner that is tolerable for the client. The older, pschodynamically and spiritually-based approaches, in my opinion, lie at the source of more profound, transformative healing.

It is clear to me that these newer approaches have, in many ways, borrowed from the founding work, wisdom, and philosophies of many great teachers, including Wilhem Reich, Shamanistic healers, and the Buddha. This fact may not be easily identifiable to the average person, given the scientific knowledge-base that appears to guides their theoretical frameworks. In my view, both the older and newer healing methods are necessary for effective therapy of severely traumatized clients. It is my hope that this paper provides anyone who reads it with some helpful information that can be utilized in their work with this population.

Trauma and Development of PTSD

The 4th edition of the Diagnostic Statistical Manual (DSM-IV) of the American Psychiatric Association provides the official definition of Posttraumatic Stress Disorder. It is available for your reference under appendix A.

Commenting on the shortcomings of this medical definition of trauma, Peter Levine (1997) states:

> "The healing of trauma depends upon the recognition of its symptoms. Because traumatic symptoms are largely the response of primitive responses, they are often difficult to recognize. People don't need a definition of trauma; we need an experiential sense of how it feels" (Levine, 1997, p.24)

Complex PTSD

For effective treatment of these clients, their etiology and chronic, pervasive, and highly distressing and disrupting symptoms (see appendix B), must be understood. Therapy/treatment with these clients requires a sound understanding of their history an symptoms in order to achieve 3 very important outcomes: 1) to accurately assess the client's needs; 2) to adequately assess what therapeutic approaches and therapist's personal resources will be most effective in meeting these needs, and will reduce the risk of re-traumatizing clients, particularly in the initial phase of therapy; and, 3) to understand and effectively work with the transference and countertransference reactions that are bound to emerge during the course of therapy. Clients afflicted with complex trauma:

> "have suffered such massive and/or multiple trauma that they lack the resources and resilience necessary for any direct confrontation of traumatic memories to be constructive. A betrayal of trust appears to figure in the overall picture of these clients. Many clients in this group have suffered at the hands of others in some way, either through neglect in their developing years or human-caused victimization at any age (abuse, assault, rape, incest, war, torture, domestic violence, etc.). The earlier this has occurred in life, the greater the damage to the ability to trust other humans. When victimization occurs later in life, betrayal of previously developed trust is the larger issue. In some cases developmental deficits (neglect or other bonding failures) may also be a factor....failures of attachment can contribute to an individual's vulnerability to developing PTSD or other disorders" (Rothschild, 2000,pp.83-4).

Fight, Flight and Freeze Responses of the Body

As will be discussed later in this paper, the ways in which our clients defensively reacted during the traumatic event has wide implications when it comes to the level of post-traumatic symptoms and disorders they may subsequently develop. Accurately assessing how these reactions affected their physiology, thoughts, emotions, physical sensations, and overall sense of Self can guide us therapists in the type of body and energy work we will embark on with them.

In *Waking the Tiger: Healing Trauma*, Peter Levine offers a compelling way of understanding the instinctual, primitive responses involved in the fight, flight, or freeze responses of all animals, including humans, when faced with imminent threat to survival. He states a:

> "Universal and primitive defensive behaviours are called the "fight or flight" strategies. If the situation calls for aggression, a threatened creature will fight. If the threatened animal is likely to lose the fight, it will

> run if it can. These choices aren't thought out; they are instinctually orchestrated by the reptilian and limbic brains. When neither fight nor flight will ensure the animal's safety, there is another line of defense: immobility (freezing), which is just as universal and basic to survival. ...In many situations it is the best choice....success doesn't mean winning, it means survival and it doesn't really matter how you get there. The object is to stay alive until danger is past and deal with the consequences later. Nature places no value statement about which is the superior strategy."

Levine's explanation of what happens in trauma is simple and commonsensical, which is of great value to both clients and therapists. Moreover, Levine shares a deep wisdom with us, using excellent metaphors for looking at the entire phenomenon of trauma and the body's innate capacity to heal itself. Though he also make reference to the psycholphysiological implications of trauma, my view is that a closer look at how PTSD develops in and affects the body, particularly the brain and the nervous system is crucial knowledge for therapists to empower themselves with. A closer look at how PTSD develops in and affects the body, particularly the brain and the nervous system is crucial knowledge This paper will attempt demonstrate why this information benefits the therapist and the client throughout the course of therapy, and can be an important asset in developing a treatment plan.

In her book The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment (2006), Rothschild uses this knowledge-base to provide a simple yet thorough description of how PTSD develops. She differentiates the workings of the limbic and autonomic nervous systems. She locates the limbic system in the centre of the brain, between the brain stem and the cerebral cortex and presents its primary functions as regulator of survival behaviours (eating, sexual reproduction, and the instinctive defenses of fight and flight, and their influences memory processing). Rothschild tells the reader that the limbic system signals to the autonomic nervous system (ANS), whether it needs to prepare for rest or effort. The ANS, comprised of the sympathetic nervous system (SNS) and the parasympathetic nervous system (PNS). It regulates the heart and circulatory system, kidneys, lungs, intestines, bladders, bowel, and pupils. The SNS and PNS "usually function in balance with each other, when one is active the other is suppressed. The SNS is primarily aroused in states of effort and stress, both positive and negative. The PNS is primarily aroused in states of rest and relaxation" (Rothschild, 2000, p.8).

Rothschild further describes the neuropsychological processes of fight, flight, or freeze, as they occur during and post a traumatic event as follows: :

> "the limbic system responds to the extreme of traumatic threat by releasing hormones that tell the body to prepare for defensive action (see an illustration of this in appendix Bi). Following the perception of

threat the amygdale signals an alarm to the hypothalamus (both structures in the limbic system) that turn on two systems: (1) activation of the SNS, and (2) the release of corticotrophin-releasing hormone (CRH). Those actions continue, each with a separate but related, task First, the activation of the SNS will, in turn, activate the adrenal glands to release epinephrine and norpinephrine to mobilize the body for fight or flight. This is accomplished by increasing respiration and heart rate to provide more oxygen, sending blood away from the skin and into the muscles for quick movement…At the same time, in the other system, the CRH is activating the pituitary gland to release adrenocortico-tropic hormone (ACTH)., which will also activate the adrenal glands, this time to release a hydrocortisone, cortisol. Once the traumatic incident is over and/or the fight or flight has been successful, the cortisol will halt the alarm reaction and the production of epinephrine/norepinephrine, helping to restore the body to homeostasis.

This system is called the HPA axis. The reason it is important to trauma is that in PTSD something goes wrong with it….the adrenal glands do not release enough cortisol to halt the alarm reactions (see figure 1.2 in appendix Bii)….While low cortisol levels are documented in PTSD (research), their cause is still a question. ….One area of interest in regards to the HPA axis and cortisol is the freezing response to traumatic threat. When death may be imminent, escape is impossible, or the traumatic threat is prolonged, the limbic system can simultaneously activate the PNS, causing a state of freezing called tonic immobility – like a mouse going dead when caught by a cat, or stiff, like a deer caught in the headlights. The chemical picture that causes the freeze must be linked to the HPA axis, but this has not been studied as yet.

These nervous system responses – fight, flight, or freeze (or tonic immobility),-- are automatic survival actions….If the perception in the limbic system is that there is adequate strength, time, and space for flight, then the body breaks into a run. If the limbic perception is that there is not time to flee but there is adequate strength to defend, then the body will fight. If the limbic system perceives that there is neither time nor strength for fight or flight and death could be imminent, then the body will freeze. In this state the victim of trauma enters an altered reality. Time slows down and there is no fear or pain. In this state, if harm or death do occur, the pain is not felt as intensely….(Rothschild, 2000, p8-10).

Classic PTSD Symptoms and Their Consequences in Daily Functioning

According to Rothschild (2006), even when the traumatic event does not result in physical harm to the body, "traumatic events exact a toll on the body as well as the mind". This is a well documented and agreed-upon conclusion of the psychiatric community, as attested in the DSM-IV: As such, a major category in the symptom list of posttraumatic stress disorder (PTSD) is "persistent symptoms

of increased arousal" in the autonomic nervous system (ANS) (APA, 1994)." (Rothschild, 2000, p.5).

Rothschild (2000) explains that, generally speaking, PTSD significantly reduces a person's quality of life due to the intrusiveness of symptoms that restrict a person's ability to function. She provides an excellent understanding of the alternating periods of hyperarousal and hypoarousal of the body's nervous system, which is so common in clients with PTSD. She also explains how reminders of the trauma can appear suddenly, often triggered by sights, sounds, physical sensations, and emotions that in some blatant or subtle manner resemble those of the traumatic event. The body can be triggered suddenly into panic, terror, etc., reactions that in and of themselves become triggers and add to the overwhelmingly unpredictable distress. When this happens, the person losses their ability to rely on bodily functions that once served to caution the body that it needs to be alert and protect against harm, danger, etc. The following consequence occurs:

> "the ability to orient to safety and danger becomes decreased when many things, or sometimes everything, in the environment are perceived as dangerous. When daily reminders of trauma become extreme, freezing or dissociation can be activated as if the trauma were occurring in the present. It can become a vicious cycle. Eventually, a victim of PTSD can become extremely restricted, fearing to be with others or to go out of her home. " (Rothschild, 2000,p.14).

To my knowledge, as seen both in the literature and in face-to-face sessions with clients, triggers can activate the following post-traumatic stress symptoms: hyperalertness, intrusive thoughts, flashbacks, nightmares, and can lead to depression (including suicidaility) , anxiety, and sleep disorders. I have had to intervene with clients impacted by complex trauma as they go into the experience of a flashback, which can be so intense that only directive grounding intervention will help the person to return to the present. To put a halt to the flashback, I often rely on the technique of having clients look around the room and name 5 things they see of a certain colour, five things they hear, five things they sense, 5 things they smell, etc. I also ask them to make eye contact with me and then proceed to ask them to tell me where they are right now, today's date, etc., while reassuring them that the memory was in the past, though it may feel as if it is happening now.

At the extreme of this, I have worked with individuals whose trauma was so severe and pervasive that their only survival strategy has been to dissociate. For clients with Dissociative Identity Disorder DID, --formerly known as Multiple Personality Disorder), dissociation happens so frequently as a survival strategy of the body, that the person's sense of Self becomes fragmented, and few or many alter parts of the person take on a distinct life and personality. The severe trauma these individuals have survived is often

of an interpersonal nature, and includes: continuous abuse of horrific proportions, including multiple and extreme forms of physical and sexual abuse, including ritualistic abuse involving animal or human sacrifices. One client with DID that I have worked with has presented to some sessions in a dissociated state, during which her alters are also experiencing intense flashbacks and somatic memories. At times, the person has been able to switch from one alter to another while in the midst of experiencing a single flashback and/or somatic memory. The following is a quote that emphasizes the importance of working with flashbacks at a body level:

> Flashbacks are comprised of dissociated, implicitly stored information (memory of the felt senses, elaborated on below) that becomes elicited under state-dependent conditions. They can be triggered by interoceptive or exteroceptive sensory cues, and are expressed through hyperarousal of the autonomic nervous system as well as behaviours directed by the somatic nervous system." (Rothschild, 2000, p.72-3).

Rothschild describes how this chronic ANS hyprarousal leads to a constant state of stress, making it overwhelming for clients with PTSD to experience the daily stressful situations that most people are able to handle. She explains how for those of us who do not suffer from PTSD, a new stress will cause the SNS to move from little or no arousal to higher arousal, and then return to little or no arousal when the stressful is dealt with. For those with PTSD, the picture is different: When SNS arousal is constantly high adding a new stress shoots it up even higher; it is easy to go over the top, causing them to feel overwhelmed. This happens because:

> "in PTSD the brain persists in calling and recalling the same alert, stimulating the ANS for defensive reaction of fight, flight, or freeze. The once protective reactions of heightened pulse, paled skin, cold sweat, etc., so necessary for defense, evolve into the distressing symptoms of disability. (Rothschild, 2000, p.47).

This often results in chronic emotional instability manifesting in pervasive fixations on the trauma related emotions. These emotions include "grief, fear, terror, or anger" (Ogden, Minton & Paine, 2006). Ogden, Minton & Pain (2006) speculate this could be due to:

> "denial or lack of awareness of the connection between current emotions and past trauma; attempts to avoid more painful emotions; the "inability to think clearly" (Leitenberg, Greenwald, & Cado, 1992); or the inability to distinguish emotions from bodily sensations(Ogden & Minton, 2000). Moreover, the emotions may relate to a variety of past events rather than only one (Fridjda, 1986). All these elements contribute to a circular, apparently never-ending re-experiencing of trauma-related emotions.

An Energy Healing and Somatic Experiencing Perspective on Symptoms

In her book, Eastern Body Western Mind: Psychology and the Chakra System as a Pathway to the Self (1996), Anodea Judith speaks to the trauma experienced in infancy from a different angle. She assesses the impact of trauma on the infant's root (first) charka. . According to Judith, the result is a rapid surge of energy moving towards the upward charkas as a result of being left with feeling a sense of "no ground", and that the breach causes these clients to lack a sense of having boundaries and personal sense of power. She mentions how this has a grave consequence on their ability to crate social support networks:

> "relationships are adversely affected by the lack of boundaries and persistent insecurity that needs constant reassurance. Communication may be blocked by fear or become excessive and disconnected from feeling." (Judith, 1996, p.81).

Judith adds that the concentration of energy in the upper charkas leads to excessive intellectualization "as a defense against feelings".

This situation just mentioned captures the typical reality of someone with borderline traits, a concurrent condition that a great number of clients with trauma, and particularly those living with complex PTSD . Though elaborating on this condition is beyond the scope of this thesis, a diagnostic description of *Borderline Personality Disorder* can be found in appendix C for your reference. To elaborate on the social handicap created by trauma, and its relation to trauma re-enactments, Judith embraces Peter Levine's theory:

> "If one's innate reaction to a given situation has been thwarted, then there is a constant tendency to recreate similar situations so as to complete the initial pattern. If the block is severe, similar situations may not allow completion, leaving us in a hopeless cycle of repeating negative traumas without being able to resolve and move on." (Judith, 1996, p.152).

Another theory that involves the role of energy in the body is that of Peter Levine (1997). He describes the experience of trauma in humans much like that of animals in the wild. He refers to traumatic symptoms such as "anxiety, depression, psychosomatic and behavioral problems" as the accumulation of undischarged energy, which originally got activated during the life-threatening traumatic event. He states, "this residual energy does not simply go away" and that if the threatened individual does not discharge the energy he/she will "become a victim of trauma". Furthermore, he believes that the traumatic

symptoms "are the organism's way of containing (or corralling) the undischarged residual energy".

This concept of needing to release undischarged energy in the body will be reviewed from other similar theoretical perspectives below.

Trauma and Memory

"Two other limbic system regions, the *hippocampus* and the *amygdala*, are especially pertinent to understanding trauma memory…Both structures are integral to processing information transmitted from the body on the way to the cerebral cortex. ..The amydala processes and then facilitates the storage of emotion and reactions to emotionally charged events. The hippocampus processes the data necessary to make sense of those experiences within the time line of personal history (i.e. "When during my life did this happen?"), and the sequence of the experience itself (i.e. "What happened first? What happened next?", etc…Nadel and Zola-Morgan (1984) have found that the amydgala is mature at birth, and that the hippocampus matures later, between the second and third year of life. Understanding the difference in the maturation schedules, as well as the functions of these two structures, provides one explanation for the phenomenon of infant amnesia—the fact that we usually don't consciously remember our infancy. Infantile experiences are processed through the amygdale on the way to storage in the cortex. The amygdale facilitates storage of the emotional and sensory content of these experiences. Hipocampal function is not yet available so the resulting memory of an infantile experience includes emotions and physical sensations without context or sequence.

Mature and adequate functioning of both amygdale and hippocampus is necessary for sufficient processing of life's events, especially the stressful ones, though during a traumatic event this may not always be possible. As the stress level increases, hormones may be released that suppress hippocampal activity, while the amygdale remains unaffected. It is possible that prolonged cortisol secretion, as may be found with trauma, affects the hippocampus in this way (Gunnar & Barr, 1988). This might account for some of the memory distortions associated with PTSD. Some individual with PTSD recall their traumatic experiences as highly disturbing emotional and sensory states, lacking the time and space context that is facilitated by hippocampal function…it appears that smaller hippocampus size might interfere with the brain's processing of stressful life events.

The *thalamus* is also part of the midbrain; its two parts flank the limbic system. It is the relay center for sensory information coming from all points in the body on the way to the cortex.

Overlaying the more primitive structures of the brain is the *cerebral cortex*, which is responsible for all higher mental functioning, including speech, thought, semantic and procedural memory. The right cortex appears to play a greater role in the storage of sensory input. It appears that the amygdale is the limbic structure through which sensory information travels on its way to the right cortex. The left cortex, on the other hand, seems to have a more intimate relationship with the hippocampus. Moreover, it appears to depend on language for processing information. Bessel van der Kolk (van der Kolk, McFarlane, & Weisaeth, 1996) has found that activity in Bronca's area, which is a left cortical structure responsible for speech production, is also suppressed (as is the hippocampus) during a traumatic incident. He describes what he calls "the speechless terror". ..(Rothschild, 2000, p.20-22)

Explicit Memory

"It is explicit memory that allows the telling of a story of one's life, narrating events, putting experiences into words, constructing a chronology, extracting a meaning.

Explicit memory of a traumatic event (of any event for that mater) involves being able to recall and recount the event in a cohesive narrative. Another aspect of explicit storage involves historical placement of an event in the proper slot of one's lifetime. Currently, there is speculation that some incidences of PTSD, may be caused, in part, when memory of a traumatic event is somehow excluded from explicit storage… " (Rothschild, 2000, p.29)

Implicit Memory

"Where explicit memory depends on language, implicit memory bypasses it. Explicit memory involves facts, descriptions, and operations that are based on thought; implicit memory involves procedures and internal states that are automatic. It operates unconsciously, unless made conscious through a bridging to explicit memory that narrates or makes sense of the remembered operation, emotion, sensation, etc.…Without implicit procedural memory, accomplishing some tasks would at best be laborious, at worst impossible. Bicycle riding provides a good example. Implicit memory makes it possible to ride a bike without thinking about it.

However, when it comes to memory of traumatic events, implicit memories not linked to explicit memories can be troublesome. It appears that traumatic events are more easily recorded in implicit memory because the amygdale does not succumb to the stress hormones that suppress the activity of the hippocampus. No matter how high the arousal, it appears that the amygdale continues to function. In some cases, upsetting emotions, disturbing body sensations, and

> confusing behavioral impulses can all exist in implicit memory without access to information about the context in which they arose or what they are about." (Rothschild, 2000, p.30-31)

Trauma and Attachment

There is great overlap and exchange of information between the trauma body of knowledge and that of the detrimental effects of some attachment patterns between infant and caregiver. Rothschild (2000) eloquently summarizes this point:

> "...babies raised by caregivers unable to meet significant portions of their needs are at risk of growing into adults who lack resilience and have trouble adapting to life's ebbs and flows. Their brains may be less able to process life's experiences. They appear to have more difficulty making sense of life's events, particularly those that are stressful, and to be more vulnerable to psychological disturbances and disorders, including drug addiction, depression, and PTSD (Schore, 1994)...the attachment relationship stimulates brain development which, in turn, expands and enables an individual's ability to cope emotionally throughout life. .it is now believed that the nurturing interaction between caregiver and infant goes a long way in promoting healthy emotional development, because that relationship, in itself, stimulates normal maturation of the brain and nervous system." (Rothschidl, 2000, p.17).

The overlapping boundaries between trauma and attachment becomes even more blurred when one considers the following:

> There is speculation that individuals who suffered early trauma and/or did not have the benefit of a healthy attachment may have limited capacity for regulating stress and making sense of traumatic experiences later in their lives. In some, it is possible that reduced hippocampal activity, either because it was never fully developed (attachment deficit) or because it became suppressed (traumatic events), limits their ability to mediate stress (Gunnar & Barr, 1998). Under those circumstances, later traumatic experiences might be remembered by some only as highly charged emotions and body sensations. In others, it may be that survival mechanisms such as dissociation or freezing have become so habituated that more adaptive strategies either never develop or are eliminated from the survival repertoire." (Rothschild, 2000, p.24-5)

Perhaps the saddest and most devastating attachment failures are characterized by those cases involving the Disorganized-Disordered Attachment style. According to findings by Ogden, Minton & Pain (2006), "This attachment pattern is characterized by "a frightened or frightening caregiver, with whom the social-engagement system is functionally off-line for most of the time". The child in this

situation usually lives with intense hyperarousal for a while, eventually collapsing into a hypoarousal response which leaves him/her feeling "deadened" and "unresponsive to interactive regulation".

According to Ogden, et. al. (2006), "unresolved trauma results in a "blockage in the flow of energy and information between two minds" (Siegel, 2001, p.88). Caregivers in this situation may be very abusive and neglectful to their infants, and make no real attempt to repair the braches. When the infant is being abused he/she is left in a prolonged state of hypoarousal and when being neglected experiences prolonged states of hypoarousal. With a compromised social engagement system, clients suffering from childhood relational trauma understandably have great difficulty utilizing relationships, including the therapeutic relationship, for interactive regulation.|"

A Bioenergetics Approach to Uncovering the Characterological Structure of Complex PTSD Clients

First a few words about the need for a body-oriented psychodynamic approach to trauma. Johnson acknowledges the value of cognitive-behavioral therapies in helping clients to avoid reaching dangerous levels of overwhelm by helping them build internal and external resources. Having said that, he also sates that ego-development requires much deeper, psychodynamically-oriented work. My personal experience in working with traumatized clients is that they need far more than cognitive-behavioural therapy (CBT) to assist them to heal at a deeper level. I also agree with his assertion that "the possibility of creative therapeutic intervention that allow for both approaches to be used complimentarily , "are numerous if one is fluent in the cognitive-behavioral areas." This premise also appears to be shared by Rothschild, Ogden, Minton & Pain, and other somatic therapy theorists and parishioners. For example, in their book Trauma and The Body: A Sensorimotor Approach to Psychotherapy (2006), Ogden, et. al. present evidence that attention solely to cognitive-behavioral aspects in assessing and treating trauma is not sufficient. They quote from Lakoff and Johnson (1999):

> ..Our concepts can not be a direct reflection of external, objective, mind-free reality because our sensorimotor system plays a crucial role in shaping them" (p.434)

Perhaps the new sensorimotor and other somatic therapies offer us a bridge between psychodynamic body-oriented approaches, such as bioenergetics. Therese newer therapies incorporate many aspects of CBT and also acknowledge the impact of a person's past history on their development. To elaborate this point (and thereby demonstrating the obvious parallel between the philosophical position of bioenergetics and that of sensorimotor therapies), Ogden et. al. provides the following rationale for the use of sensorimotor (body) work with traumatized clients:

"All early relational dynamics with primary caregivers, traumatic or non-traumatic, serve a blueprint for the child's developing cognitions and belief systems, and these belief systems influence the posture, structure, and movement of the body, and vice versa... Chronic postural and movement tendencies serve to sustain certain beliefs and cognitive distortions, and the physical patterns, in turn, contribute to these same beliefs." (Ogden, Minton & Pain, 2006, p.19)

As this pertains to the development of personality, they quote Kurtz and Prestera:

> "Such physical patterns become fixed by time, affecting growth and body structure, and characterizing not just the moment, but the person. Rather than simply a present disappointment, the crushed posture of hopelessness could be pointing to a lifetime of endless frustration, and bitter failure." (1976, p.1).

The utter limitations in regard to emotions and physical actions that this predicament poses the traumatized person, goes along way to providing insight into the necessity of addressing the body in trauma treatment. In my experience, I have found that extensive, practice-based training in bioenergetic psychotherapy to be invaluable. Bioenergetics allows the therapist to develop not only a more thorough insight into various characterological structures that form across the various developmental stages, but also teaches us to apply effective body-oriented techniques aimed at helping clients create a new and profound psychological, postural, and sensory imprint while resolving the impact of traumatic life events. For a client, creating a new imprint with a trusted therapist can help him/her to reclaim their right to be cared for and attended to in profound ways. By assisting a client to gradually develop those physical, psychological, cognitive, and emotional buffers that were not present during their childhood developmental years, bioenergetic therapy can be an incredible avenue for transformation.

The Schizoid character Structure with Borderline Attributes

Johnson (1985) provides a valuable etiological and characterological analysis, as well as prudent treatment recommendations for the client whose primary charactrological structure is that of the "schizoid" or "hated child". Given that the scope of this thesis is limited to clients with complex PTSD (many whom were traumatized in infancy), it is also limited to reviewing this particular structure as it is of most relevance here, and often most dominant in the severely traumatized clients I have worked with. Though there are some clear differences, Johnson's work resonates well with that of the other body-oriented approaches in the assessment and treatment of the client having suffered prolonged, interrelation trauma in infancy, and likely through the entire course of their primary developmental years. Johnson emphasizes the following key concepts when referring to the development of this structure:

> "The infant's natural initial response to a cold, hostile, and threatening environment is terror and rage. Yet, chronic terror is an untenable position from which to lead a life, as is chronic rage. Furthermore, such rage invites retaliation, which is experienced as life-threatening and terrorizing. So, the infant turns against herself, suppresses the natural feeling responses, and uses the very primitive ego defenses available in the symbiotic period to deal with a hostile world. In addition to, or as part of, the retreat to autism, the organism essentially stops living in order to preserve its life. The ability to do that is limited by the ego development of the infant in this period. However, through the months of symbiosis she can regress to the previous developmental period and in that deny the reality of her existence. The hatred of the caretaking parent will be introjected and will begin to suppress the life force of the organism, such that movement and breathing are inhibited and there develops an involuntary tightening of the musculature to restrain the life force."

This analysis of the schizoid character's defensive responses to the trauma addressed the intolerable, overwhelming thoughts, emotions, and physical sensations that infant must repress in order to survive. Similarly, the theories presented by recent somatic therapeutic approaches also acknowledge the same level of distress which occurs across these three central body and mind processes. However, the difference appears to lie in that tracking these defensive responses in the body, from a bioenergetic lens, focuses primarily on breathing, the musculature and skeletal tensions and blockages. Johnson refers to the schizoid structure with a "borderline nature" to describe the client who survived some of the most harmful forms caregiver abuse. In harmony with some of the somatic therapeutic approaches that are examined in this paper, One similarity lies in the fact that Johnson expresses the need for therapy to be adapted with such clients, so that the body-work does not overwhelm the client's system. In regards to utilizing active body-oriented techniques Johnson makes this cautionary note:

> "It is important to be aware that borderline individuals with a basic schizoid structure may be overwhelmed by active body techniques and may find them to be a real intrusion if they are not preceded by considerable work of a "softer" nature." (Johnson, 1985, p.98-9).

In *Characterological Transformations: The Hard Work Miracle* (1985) Johnson dedicates a section to "the first category of awareness-relaxation" exercises. Or "body processes which enhance grounding and sensory awareness and provide a warm-up for more charging and discharging processes." Therefore, much like the newer trauma-focused somatic therapies, Johnson also provides a structured and systematic body-oriented therapeutic approach that can be divided into 3 categories (which may at times overlap). He describes the 3 categories as follows:

> "A number of exercises are used to promote the relaxation of chronic tension and increase sensory awareness. These exercises often involve some form of stretching the body together with focus on breathing and will be called *awareness-relaxation* exercises. The second group of exercises is devoted to *building an energy charge* in the body; these exercises substantially increase respiration, circulation, and movement. In simple language, these exercises "get the blood pumping." A third group of methods is devoted primarily to the *discharge* of energy or affect. " (Johnson, 1985, p.99)

A more detailed description of some of the exercises within the first category will be presented in the next section..

<u>Treating Trauma: A Multidimensional Approach</u>

The Essence of Body Work: A Chakra Systems Analysis and Energetic Healing Perspective

Energy lies at the source of the body's functioning, and therefore is a key concept in understanding trauma. Without a continuous and balanced energy flow in the body there is no life. Trauma severely compromises the ability of the body to have a balanced energy flow and thereby the life-functions of the body get severely compromised. The a general etiological picture of clients impacted by complex trauma is captured eloquently by Anodea Judith (1996), who explains that the infant who experiences trauma t receives severe damage to the first charka. She states that due to abuse and neglect:

> "the child falls into an intolerable pit of fear and helplessness—the experience of having no ground. When this happens the downward current of energy is blocked. Instead, the life force moves towards the upper chakras, which feel safe. The upward movement then becomes habitual, depleting the lower charkas and sending the system out of balance....Recovery from these traumas is a distinctly nonintellectual process. It requires returning to the movements and messages of the body, immersing ourselves in our physicality, and reconnecting to core impulses." (Judith, Eastern Body Western Mind: Psychology and the Chakra System as Path to the Self, 1996, p.71)

Judith explains that as the child continues to experience threat to survival, he/she tries to cope by redirecting his/her attention "away from the unpleasant experience and cuts off bodily sensations. The downward, grounding current is inhibited as much as possible , directing most of the energy to the head.(Judith, 1997). Judith emphasizes the detrimental impact of being disconnected from the body as impacting on many levels, including a lack of awareness about internal states that signal basic needs for food, sleep, and medical attention, as well as a lack of bodily sensations that facilitate attunement to the emotions of others

thereby causing a disruption in the person's ability to form and maintain relationships. Her characterological description resembles that of Johnson's schizoid character structure at the borderline extreme:
A person with an accelerated upward current is hypervigilant to messages outside of herself , as if constantly searching for ways to connect with her caretaker or constantly watching for danger. This is the hallmark of a deficient first charka: the body is deadened and the consciousness is elevated, creating a profound mind-body split." (Judith, 1996, p.79-80).

According to Judith (1996), energy work aimed at healing trauma, resulting in first/root chakra, requires that the therapist pay more acute attention to the client's "energetic statements" than to his/her emotions (that is not to say that emotions are ignored all together). She presents a systematic approach to working with the charka system, thereby keeping in line with the opinion that trauma work should, whenever possible, follow a systematic approach that prevents the client from becoming overwhelmed and therefore derailing the therapy. I will now provide an overview of the exercises the Judith recommends for the healing of first charka/schizoid characterological issues. To stay focused with the theme of this paper, I am only interested here, with those that lend themselves to containment during the initial phase of therapy with complex PTSD clients. Judith also emphasizes that it is imperative to help the client build internal resources that facilitates the client's ability to ground and contain strong sensations, before work on processing emotions can take place:

Judith (1996) identifies grounding as the very first step in working with a traumatized individual, stating that :

"Learning to develop the downward current of the body and literally and literally building a ground just as one build a foundation—brick by brick—is what is needed for the top-down structure in which the upper charkas dominate". To make this point about keeping the work safe and effective, she has the following: to say:

> "Keeping the person focused on bodily sensations rather than focusing on the emotions helps provide containment for difficult traumatic material. The person can focus on what her body is *doing* without getting lost in the feelings, which are more characteristic of the second charka. This is done through constant reference to, and mirroring of the physical processes that are experienced during the session. "When you feel scarred what does your body do?"What happens in your belly or your breathing?" A person can learn to gain some relief from painful emotions simply by changing their *physical* expression, without tumbling down the labyrinth of historical content and emotional soup. A simple grounding suggestion can also bring greater strength and calm, such as" What happens when you put your feet back down on the floor and press

your weight into them" "What happens when you stand up?" (Judith, 1996, p.91)

This concept of creating a stronger container in the body (by paying attention to the body vs. the emotions), to assist the client to eventually tolerate trauma work, is shared by Johnson, Rothschild, Ogden, et. al, and Levine, as is the concept of grounding the client in the present moment. Furthermore, sensing, lowering, raising, and balancing energy in the body appears to be the common denominator to it all. Let's continue to with this hypothesis.

The sequence of techniques that Judith (1996) suggests in healing work with the first charka draws from and/or reflects various approaches and therapeutic techniques that lend themselves to conducting therapeutic body and energy-work. For example, the therapist can utilize expressive arts and have the client draw his/her body on paper, asking him/her to draw what his/her body feels like in order to elicit unconscious feelings about what is going on with the client energetically, without accessing the client's intellectualization of their perspective. Body dialoguing is another exercise, in which Judith utilizes the metaphor of the client (in a relaxed state) pretending to be a consultant interviewing the body parts which represent the membership of the corporation (body). Through this method she gets client to express how each part of her body is feels "about their job and position in the company". This technique allows the client an opportunity to gain insight into "how the body is expressing her life experience".

Another approach comprised of a multitude of recommended actions and techniques is presented by Judith (1996). It is aimed at affirming the physical experiences of the client and teaching new, more grounded, ways to experience the internal body and the external world. New actions include learning to enjoy the pleasure of a nurturance of the body via gentle massage that helps to break down the defensive "armoring" (a bioenergetic concept) of the client. Techniques such as getting the client to exaggerate an uncomfortable, tense, or painful bodily sensation, contrasted by a relaxed, grounded feelings, can help the client learn that he/she is able to change old habitual maladaptive patterns that keeps the person fixated on negative trauma-associated emotional states. To highlight the interrelationship between the physical body and the emotional experiences of the client, Judith offers good advice as to the importance of following a systematic approach:

> "...Change in the physical structure helps support a new emotional response, and change in an emotional expression helps support new physical postures. Both sides must be worked simultaneously, but emotions are more appropriate to the realm of the second charka, so we will focus here on the physical." (Judith, 1996, p.95)

Another exercise aimed at grounding and changing habitual maladaptive postural patterns is that of working on the feet. Judith (1996) provides an excellent

overview of the benefits of teaching the client to sense the subtle, both conscious and unconscious, intricacies of their felt sense of their feet, weight distribution, and energy flow blockages. In order to assist the client to experience a new felt sense of confidence, assertiveness, and groundedness, Judith also encourages the act of doing psychotherapeutic work while the client is in a standing position. The client is encouraged to embrace life by consistently working on unlocking the knees. This is done by asking he client to sense the difference between locking the knees and experiencing energy blocks that lead to a posture of "defeat" and "deadness", versus aliveness obtained via keeping the knees slightly bent and the body's centre closer to the ground.

Judith utilizes grounding exercises in much the same fashion as is done in bioenergetics. Similar to other sensorimotor, and somatic therapists, she also uses caution when gauging whether the client should "put on the brakes" if they begin to experience a stronger energy charge during this exercise, or help the client work towards resolution of the issues being recalled. She states that knowing whether the material can be worked through within the session is accomplished via "intense observation and constant dialogue that keeps her in touch with both her physical and emotional states.". As will be seen below, Ogden et. al and Rothschild utilize tracking and dialogue in much the same way.

If it is possible to conduct this work the grounding benefits to the client could be great:

> "As the person begins to resolve the issues brought to light by the exercises, the grounding gains solidity. She is literally resolving that which has stood between herself and her ground. As this occurs, problems with jobs, housing, and physical ailments—all first charka issues—begin to resolve. (Judith, 1996, p.99)

In my own experience of grounding work with complex PTSD clients, I have found that anxiety, nausea, etc., can often be triggered. This has forced me to rely on my intuition to decide whether the exercise should be discontinued or whether it should lead to further processing. I have found that as I sense that my clients' sense of safety and trust in the therapeutic connection increases, we are able to proceed with grounding, either by having the client stand or lie down with feet pressing gently into the mattress as the client exhales. Slow rhythmic breathing into the belly and exhalation into the mattress seems to be enough to facilitate dialogue about how the client's strong physical sensations, thoughts, and emotions are being experienced by him/her.

By instructing the client to maintain mindful awareness of his/her sensations, I have experienced profound attunement to my clients which has guided the natural flow into exploration, processing, and/or resolution of deep, trauma-related material. I have discovered that a useful anchoring technique involves asking the client to vividly imagine being at a safe or sacred physical place that is

known to the client. This is anchoring approach is borrowed from the works of Peter Levine, Babette Rothschild, Pat Ogden, Kekuni Minton, and Clare Pain, and have found this technique to be effective in safely taking the client towards trauma-related material. I have also cautiously incorporated hands-on energy healing work (taught to me by John Went of the Integral Healing Centre of Toronto) to assist the client to experience a more profound healing experience.

A glimpse into the next phase of Judith's trauma work takes place in a gradual manner. Perhaps it would be helpful to take an excerpt from Judith to describe how she proceeded to work energetically with a client whose traumatic response was to freeze::

> "Knowing that there was a fair degree of trauma behind his frozen response, I proceeded carefully and spent several weeks gently charging and discharging through movement before getting into the content of the trauma. Like a pressure cooker, this energy needed to be released slowly before taking off the lid. I encouraged various movements of the arms and shoulders, which allowed him to connect more deeply to his body's ability to move. Understanding the block as trapped energy, I knew I needed to open things up in order to clear out the energy. Allowing the arms to regain their mobility created an opening and decreased his feeling of powerlessness. Gradually I began weaving his historical material and emerging emotions into the movements, which soon changed from random motions to purposeful expressions. He learned to use his arms in accordance with his inner needs, alternately reaching out for support or pushing away to establish boundaries. With boundaries and a sense of power and grounding established, it became safe to work more deeply on the emotional material. We gradually thawed the ice in his body and restored emotional flow.| (Kidotj. 2996. 152-3)

Addressing Trauma Re-enactment from an Energy Healing Perspective

> "When past trauma are severe, the emotions of rage or helplessness can re-traumatize and trigger the nervous system into its familiar traumatic stress patterns. When damaging emotional habits are a presenting complaint (raging uncontrollably, crying too easily, feeling paralyzed by fear), it does not help to dig these emotional habits into deeper grooves. When any of these factors are present, it is better to facilitate containment and behavior modification than it is to release." (Judith, 1996, p.159)

Levine (1997) explains how clients can be assisted to put a halt to traumatic re-enactments through the conscious completion of a traumatic action. He uses the metaphor of a stream to represent life, and the banks of the steam to represent the body, and its ability to contain life-energy and allow it to freely flow, "It is the

> "When these brain functions work as one, we can establish a special relationship between the mainstream for our internal experience and the turmoil of trauma. Moving slowly and allowing the experience to unfold at each step allows us to digest the unassimilated aspects of the traumatic exprience at a rate that we are able to tolerate." (Levine,1997, p.188).

According to Levine, it is not necessary to "dredge up old memories", as doing so could "suck" the person back into the "trauma vortex", and create unnecessary hyperarousal. He strongly believes that employing intense emotional release techniques to work with traumatic symptoms is a mistake. Moreover, he warns therapists that working to recall and process traumatic memories is not the answer to resolving trauma as they can usually only be accessed in fragments and accuracy of the memories is never truly known, however, can create strong and disruptive fixations that can keep the person stuck in the traumatic experience, re-enactments, and the "victim role". He believes that focusing on memory leads to contraction rather than expansion (which he believes is crucial for true healing to occur). Contraction restricts the client from connecting to the flow of his experience and from accessing the felt sense that can guide the haling process. In addition, he is clear that completing the natural activation with the assistance of the somatic experiencing body-oriented techniques, is the only way to truly heal trauma. He assets, "The key to transforming trauma is to move slowly in the direction of flexibility and spontaneity." This allows the client to connect with the present-moment flow of his/her energy with the help of a body-oriented therapist. He has the following to say in respect tot his:

> "When this happens we see the appearance of powerful experiential collages that are perceived (to the degree of their intensity) to be "true" memories. It is not important whether memories are objectively accurate. Of prime importance is whether the associated activation escalates or resolves. It is essential that the unresolved activation locked in the nervous system be discharged. This transformation has nothing to do with memory. It has to do with the process of completing our survival instincts," (Levine, 1997, p.215)

<u>Healing Trauma via a Bioenergetics Therapeutic Approach</u>

Earlier in this paper I introduced the three categories of bioenergetics exercises recommended by Johnson. The first category of "softer" exercises includes body work aimed at: focusing and creating a physical grounding stance in a standing position, with the client turning his/her awareness inward to notice the sensation that are present in the body; enhance physical grounding by instructing the client to go into a "forward position" which involves having the upper body hang forward in a lose fashion while small bending movements in the legs are synchronized with "nice and easy breathing"; footwork to increase sensations in the feet

(enhanced by the use a dowel) are used in combination with continuous easy breathing; loosening the joints of the toes with slow easy breathing; stretching the ankles to further enhance feeling and flow of energy in the ankles; with permission from client, lightly pummeling (massage) the upper back, shoulders, and neck while asking client to make an "ah" sound that aids in the releasing of bodily tensions in this region; and lastly, completing this sequence with neck stretches and head rolls. It is important to note that the forward bending position is encouraged throughout this sequence as a way to enhance grounding, deepen breathing, and if appropriate, to begin to build a charge in the body (Johnson, 1985, p.100-4).

Johnson alerts therapists to use caution when using these exercises with "borderline" clients, and suggests that more sensory, rather than more active exercises, are sometimes more suitable with this traumatized population.

> "...because of the borderline nature of some schizoid patients, very little movement or affective release can be overwhelming. Consequently, it is useful to have a repertoire of processes which enhance sensory awareness without requiring that the patient become very active." (Johnson, 1985, p.95).

Johnson adds another very important cautionary note about ensuring that the body-work will be in synchronicity with the available ego defenses of the individual, so as not to overwhelm the individual:

> "...at this point, however, there exists a crossroads at which the well-defended schizoid character goes in one direction whereas the borderline character must stay behind, strengthening the gains outlined in this chapter and further developing ego abilities...When the ego abilities are sufficient either initially or through treatment, we can then move on to those objectives which require more insight and more affective release. " (Johnson, 1985, p.122-23)

Johnson therefore stresses the importance of teaching the client new defenses by conducting resource enhancing and/or accessing therapeutic work. He eloquently states this by saying:

> "One constructive way of looking at the schizoid problem is to see the hated child as one who has a great deal to defend against but with only limited and primitive defenses. The feelings in the schizoid's body are overwhelming and the demands of the environment are much more than can be handled given the arrested functioning in the early symbiotic period of development. Before this person will ever be able to relax and confront the terrible feelings within him, he must feel safe, not only with the therapist, but also with himself. That is, he must feel that he can put himself back together if he allows himself to come apart and that he can

> stop the release of feelings short of disintegration or destruction. The simple defenses of denial and projection are generally not sufficient to provide that kind of safety and it is therefore useful to teach him other ways of defending against the internal emotions and coping with the external environment before more internal, affective objectives can be realized. " (Johnson, 1985, p.115)

Citing the effectiveness documented in existing research, on "meditational and general self-administered relaxation programs", Johnson finds them so profoundly effective that he recommends them to practically all of his clients Johnson, 1984, p.96). In his book *Characterological Transformations: The hard Work Miracle*, Johnson offers the "I am...." Meditational exercise which aims at helping the person gain awareness of their current physiological and emotional state in the present moment, noticing the ebbs and flows of "being with" whatever feelings and physical sensations arise. Johnson suggests that when the client has reached a "desired state", he/she "open her eyes and look around the room slowly while attempting to maintain the state. If the client begins to lose contact with her/himself, he instructs the client to close her/his eyes again and repeat the exercise until contact with the self is regained. Once the client open her/his eyes again Johnson tells the client "if you begin to go away, or lose yourself, close your eyes, go inside, and repeat the exercise until you can come out and once again look at me". At the end of the process the client is asked to share her experience.

The "I am..." exercise poses some of the same benefits of the self-awareness exercises that somatic therapies utilize in helping clients slow down and contain their cognitive, emotional, and physiological traumatic reactions during therapy. Another similarity lies in the ability to ground the individual in the present moment so the client does not experience a re-traumatization.

In the initial phase of therapy with a client presenting with schizoid charterolgical issues, it is obvious to the therapist that deep insights and effective emotional releases will not be achieved for quite some time. Johnson proposes that instead, the client can be provided with a simple explanation of his/her charactorological issues. The therapist provides a clear explanation of how an understanding of childhood development can explain many of the adult client's emotional problems. The client is assisted to understand how his/her strategies for coping with adult problems are often child-like, with an emphasis on normalizing how these strategies and associated defenses get crated. This is intended to promote insight, understanding, and compassion for self and others.

In addition, because a client with a schizoid character structure is comfortable with intellectualizing, he/she may be receptive and welcoming of this explanation during the initial step in therapy. Furthermore, this explanation can serve to combat the client's "introjected, judgmental, self-hating aspects", which in my

experience are well invested in sabotaging any therapeutic progress. An explanation can empower the client with the ability to develop self-compassion for the wounded inner child, and utilize problems of daily living as opportunities to cultivate further insight and understanding of oneself. Johnson speaks to the resource-enhancing capacity of this approach for the more severely traumatized client:

> "The adoption of the new "analytic attitude" or the "observing ego" can give the client a new and powerful cognitive ego ability, the impact of which is far reaching. This will be particularly valuable to the more borderline or less well-defended client in giving him an extraordinarily powerful and useful defense". (Johnson, 1985, p.86)

As mentioned earlier, grounding is essential for the client with a borderline schizoid character structure. Johnson states:

> "Increasing the sense of grounding and developing the client's sense of his body and environment are the very beginnings of realizing the real self. In a bioenergetic sense, grounding means having a real experience of one's legs and contact with the ground—feeling the support of the legs, the contact with the feet, with the floor, developing th4 sense of one's place in the world. The well-grounded person knows where he stands or knows when he is not on solid ground and his stance needs to be changed. He is in good contact with reality and with his position in the world. He is not a pushover but can stand his ground....This will pave the way for an increased capacity to experience and tolerate feeling and to literally have a greater sense of himself from the ground up...there is greater consciousness of what is felt both internally and externally, as well as of what is heard and seen." (Johnson, 1985, pp.94-95

Johnson believes that true healing for a client with a schizoid structure takes place when the client can accomplish the following:

> "begins to get into himself and progress through the and expression of the deep feelings within toward an integration of the real self within his real world. To do this the person must come into conscious contact with the terror and rage, which have, usually for decades, been repressed. He must take responsibility for what is within and ultimately stop projecting his own distress outward. While the elicitation and understanding of the core affects are necessary, that alone cannot really heal until the schizoid takes responsibility for being the host of these feelings. A good solid step in this direction of responsibility is taken when the individual is ready to appreciate how he plays the game of the schizoid: denying feelings, projecting feelings;, and foisting responsibility onto others." (Johnson, 1985, p.124)

Many active bioenergetic exercises that will not be elaborated on in this paper can be introduced once the client has built sufficient ego defenses. These are designed to accomplish deep emotional releases and the creation of a new transformative imprint in the client's body and life. As the client is able to tolerate them. As explained in the various sections of this paper, such accomplishments will require much patience and commitment, and trust in the healing process. It will also require the use of many helpful techniques that allows the client to work through strong emotions, physical sensations, and seemingly infinite defensive reactions that will lead to transference and coutnertransference reactions. Rothschild and Ogden, et. al. provide extremely useful techniques to lower a client's arousal level during the different stages of trauma-focused therapy. These can easily be incorporated with a bioenergetic and energy healing approach to make the achievements just outlined a safe and more easily accessible reality for the client with complex PTSD..

The Role of Psychophysiological Theory in the Treatment of Trauma

The tools presented in this section are inspired by a variety of body-oriented therapies, scientific knowledge available on the physiology of the body and its pertinent treatment of trauma, combined with the wisdom and simplicity of mindfulness, systematic resource creating approach of cognitive-behavioral science, and other common sense approaches.

Rothschild (2000) and Ogden, et.al. (2006) provide us with some hands-on tools that we can draw on to deal with the urgent and often chronic trauma-ridden material that emerges, resulting in flooding and an overwhelmed state. As therapists, we can incorporate these simple methods to ensure the hyperarousal states of our clients do not prevent integration of a new healing imprint. To illustrate this point, let's begin with an overview of what happens when the client is permitted to remain in a state of hyperarousal.

Assessing Type of Trauma: Importance in Treatment Planning

An important factor in trauma treatment planning involves effectively assessing the type of trauma and traumatized client one is dealing with. Lenore Terr (1994) identified two distinct types of trauma. "Type I refers to those clients who have experienced a single traumatic event. Type II refers to those who have been repeatedly traumatized" (Rothschild, 2000, p.80). Terr also identifies two subtypes of Type II clients:

> "Type IIA's are individuals with multiple traumas who have stable backgrounds that have imbued them with sufficient resources to be able to separate the individual traumatic events one from the other. This type of trauma client can speak about a single trauma at a time and can, therefore, address one at a time. Type IIB individuals are so

> overwhelmed with multiple traumas that they are unable to separate one traumatic event fro another. The type IIB client begins talking about one trauma but quickly finds links to others—often the list goes on and on. Type IIB individuals can also be divided into two categories: The type IIB(R) is someone with a stable background, but with a complexity of traumatic experiences so overwhelming that she could no longer maintain her resilience. Typical of this type of client are the Holocaust survivors described in the aforementioned Norwegian study by Malt and Weisaeth (1989). Type II(nR) is someone who never developed resources for resilience, as described by Shore (1996)." (Rothschild, 2000, p80)

What is important here is to be aware that Type I and Type IIA clients already "internalized the resources that might be offered within the framework of a long-term, transference-focused relationship" (Rothschild, 2000, p.81). Therefore, according to Rothschild, these individuals likely require less attention to transference related issues that arise in therapy, and can thereby move quicker towards processing their traumatic material. For Type IIB clients, however, the resources needed to work through their traumatic material will be developed via the transference that arises within the therapeutic relationship. Type IIB(R) clients will need the therapeutic relationship to "reacquaint" them with resources they originally had but lost due to the complex trauma they experienced. Type II(nR) will need the therapy to focus on resource and resilience development for a considerable length of time given that they never had the opportunity to acquire. More on the issue of transference and counter-transference will be elaborated on in a later section of this paper.

Affect and Pain Regulation

Rothschild (2000) makes reference to the work of Allan Shore (1994), who has been key in identifying how clients who experienced poor attachment styles in the childhood developmental years, were not able to develop affect regulation abilities as a result. Shore points to the three phases of this attachment process: "attunement, misattunement, and reattunement". Attunement is based on a tolerable level of connection between caretaker and child. Misattunement is characterized by the infant breaking contact with the caretaker as a result of experiencing intolerable levels of arousal, due to too much excitement, and/or the perception of anger or disapproval from the caretaker. In reattunement, the infant re-establishes contact with the caretaker once the arousal level decreases to a tolerable level, however, this time, at a higher level of arousal than was previously tolerated. Rothschild points out that knowing this can be of great help to the therapist in preparing the client for whatever transference will inevitably arise in the therapy. This can be accomplished by explaining the concepts just described and having a discussion with the client about the predictability that misattunement and re-attunement will be taking place in the therapeutic relationship. Of most importance is the opportunity to educate the client about

the importance of such transference in crating an opportunity for possible reattunement within the therapeutic relationship, something that the client would likely not have experienced enough with his primary caregivers.

The Importance of Safety In the Client's Life: Building Internal and External Resources

" The first rule of trauma therapy is safety (Herman, 1992)". This is one concept that has always stayed with me ever since I read Judith Herman's book Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror. Herman stresses that no healing can ever take place if a client continues to live in an unsafe and/or traumatizing environment. This knowledge has served me and my clients well in treatment planning with complex PTSD clients who were still tied to their perpetrators, in one fashion or another. I recognized that no significant trauma-focused work could ever take place if safety planning, whether this meant reporting abuse to the police and accessing the court's protective measures, moving, working on simply supporting the client to make her environment safe by changing her locks, disconnecting her telephone line, being escorted when outside of her home, enrolling in a self-defense class, etc.

Rothschild recommends that one way to instill a better sense of safety in the client is to help him/her to temporarily remove a trigger. This can "reduce or eliminate its effects and it can be returned to the client's life with little or no consequences. An example of this was provided by Rothschild who asked a client to stop using the shower (the trigger) for a period of a month. When the client returned to taking showers he was no longer experiencing terror.

Another strategy recommended by Rothschild (and what I have experienced intuitively as common sense), is to ensure a sense of safety for the client in the therapeutic setting. This implies avoiding any trauma-focused therapeutic techniques until the client has developed sufficient trust in the therapist. The length of time will, of course, vary from client to client.

There are four types of resources that Rothschild recommends the therapist assist the client to either develop or reacquaint with. The first are *functional resources*, or otherwise known as practical ones like the ones just described above. The second category is that of *physical resources*, which includes helping the client to access whatever exercise or muscle toning routine will be adequate to instill a sense of strength and empowerment. The third category is that of *psychological resources*, comprise of already existing abilities or attributes of the client, i.e., intelligence, creativity, etc.), along with coping defenses, i.e. withdrawing, anger, etc. In regards to coping defenses, the client can be reminded as to how these defenses have served him/her well to an extent, and encouraged to develop the opposite of the defense (i.e. social connection, restraint) to the degree that will provide the client with a sense of choice that can lead to balance. *Interpersonal resources* are those of a personal and significant

social support to the client and can include memories of past supportive people or animals. *Spiritual resources* are those that center around a client's belief or faith in a higher power, whether religious or non-religious. In addressing a therapist's reluctance to support the strengthening of these resources, Rothschild has this to say (which I strongly support):

> "One must come to terms with this countertransferential response, since spiritual resources can be very powerful aids to the healing of traumatic conditions. In addition, some victims of trauma feel betrayed by their beliefs. For those individuals, reclaiming the lost relationship to the spiritual will be a crucial step toward healing." (Rothschild, 2000, p.91)

Do no Harm: Ensure Clients Remain Within A Window of Arousal Tolerance

According to Rothschild (2000), trauma therapy becomes traumatizing "when more memories are pressed or elicited into consciousness—images, facts, and/or body sensations—than can be integrated at one time. "(p.78) In addition, Rothschild explains that "The major indicators of overly-accelerated therapy is that it produces more arousal in the client's autonomic nervous system (ANS) than he has the physical and psychological resources to handle" Rothschild, 2000, p.78). Rothschild provides the metaphor of a car speeding out of control with a driver who is unable to find and/or put on the brakes. Therefore, the first concept that becomes crucial in trauma therapy is that of "learning to put on the brakes". Both client and therapist must learn how to accomplish this.

Putting on the brakes refers to the process of reducing the client's hyperaroused state so that the client can experience rest and relief from the almost constant experiencing of this state. The analogy of "the pressure cooker, provided by both Rothschild (2000) and Judith (1996), can be used to explain how:

> "unresolved trauma can create a tremendous amount of pressure both in the body and in the mind in the form of ANS hyperarousal. "Once the pressure is built up, it becomes impossible to open it, but if you could it would explode. You must first slowly relieve the pressure, a little "pft" at a time. Then and only then can you open any pressure cooker safely....If you try to open the client up to trauma while the pressure Is extreme, you risk explosion—which in a client's case can mean decompensation, breakdown, serious illness, or suicide. However, with judicious application of the brakes to gradually relieve the pressure, the whole process of trauma therapy becomes less risky. Each client should be evaluated on an individual basis. Some require more liberal braking than others. Optimally, the pace of the therapy should be no slower than necessary, but no quicker than the client can tolerate while maintaining daily functioning." (Rothschild, 2000, p.80)

Ogden, et. al. (2006) describes the 3 phases of trauma treatment applied within their sensorimotor approach. The first phase involves the development or reacquaintment with, somatic resources, which include many of the resources already mentioned by the body-oriented therapeutic approaches that have been examined in this paper. In addition, Ogden, et.al. offer other physiological and psychological techniques that assist clients to maintain their arousal levels within a window of tolerance. Their work is consistent with the belief that remaining within a window of tolerance is crucial for the integration of therapeutic work and adaptation to the functional demands of daily life. They stress the importance of teaching clients to "experience the dysregulating emotions and arousal without reacting self-destructively (e.g. engaging in self-harm, dangerous activities, violence, suicidal ideation), or otherwise maladaptively (Steele et al., 2006)". Ogden, et. al. explain that in the first phase of therapy the following goals are accomplished:

"Gradually, through the interactive regulation of the therapist, combined with psycho-education, recognition of the triggers, and mindful observation of their own arousal, and defensive subsystems, clients learn to become aware of when their arousal exceeds the window of tolerance and to implement resources that help them stabilize at those times." (Ogden, et. al, 2006, p207)

Tracking of the client's body is consistent throughout this first phase of treatment, "to assess existing somatic resources—for example, deep regular breathing, extension in the spine, flexible movements, sturdy legs, relaxed shoulders, ability to make eye contact—as well as the chronic signs of dysregualted arousal and truncated defenses: (Ogden, et. al, 2006, p..207). For complex PTSD clients that are not able to tolerate the very valuable energy charge releases bioenergetic exercises that ,combined with a psychodynamic approach, lead to deep characterological shifts in clients. Gentle sensorimotor exercises can be a great alternative and compliment to the grounding, self-awareness (first category) of bioenergetic exercises.

Examples of sensorimotor techniques of this sort may include asking clients to identify their personal sense of boundaries and proceed to carry out a "pushing? or "reaching out" exercise with the assistance of gentle tension provided by the therapist and/or his/her props (i.e. pillows, exercise ball, etc). The client is asked to oscillate between his/her usual posture of, for example "defeat", and the new posture that provides the client a sense of empowerment. By having a client remember a time when they felt confident, strong, and/or competent, and then have the client track the straightening of their spine and raising of their chin that occurs as a somatic response, clients can use this felt body sensation as an anchor in the therapeutic work to come. According to Ogden, et. al. (2006), "The goal of resource work in phase 1 is to develop a sufficiently broad range of somatic resources to

modulate arousal." These authors stress the importance of interrupting the client as he/she becomes overly aroused while narrating his/her story. This can be accomplished though a gentle invitation to focus on body-awareness in the moment, and a promise to continue with the narrating of the story once the client is calmer. Reconnecting the client with resources is very appropriate during these times.

The following is an example of an oscillating technique:

"shift back and forth between an image , sensation, or experience that evoked positive feelings, and one that evoked negative feelings. For example, as one client complained of hyperarousal accompanied by a terrible headache, the therapist asked hi to imagine a visual picture that represented the pain in his head and a picture that represented the opposite. The client immediately had an image of the inside of a golf ball that represented the pain, whereas a marshmallow represented the opposite. As the therapist asked the client to oscillate between these two images and noticed his body's response, the hyperarousal and the headache began to disappear." (Ogden et. al, 2006, p.218)

The Role of Mindfulness: Developing Dual Awareness

Rothschild explains the role of dual awareness in preventing re-traumatization during therapy:

> "It is not possible for clients to safely address traumatic memories until and unless they are able to maintain a simultaneous awareness and discrimination of past and present. They must be able to know, at least intellectually, that the trauma being addressed is in the past, even though it may feel as though it is happening now. Delving into traumatic memory with a client who is unable to maintain this dual awareness risks uncontainable hyperarousal and a possible dive into flashbacks. This is fertile ground for re-traumatization: re-experiencing trauma with all the terror, hopelessness, and desperation first tied to it." (Rothschild, 200,pp.130-1)

Dual awareness implies that the client will have to learn to both develop an awareness of oneself in the experience of the PTSD symptoms, and as the observing self of that experience. The key to safe trauma work is the ability of the client to be mindfully aware that the flashback, nightmare, intrusive thought, etc., they are experiencing in the present, are bringing up the same emotions, physical sensations and cognitions that were overwhelming when the trauma actually took place, but that the trauma is not actually happening in the present. A technique of dual awareness I previously mentioned which I use to teach clients to gain mindful awareness of the reality of the present moment, is that of asking the client to name 5 things they see, hear, feel with

their senses, smell, etc. In dual awareness the client is brought back to the present moment via one such technique and then is asked to engage in symptom halting exercise. The following example will serve to clarify this:

"The client says, preferably out loud, the following sentences filling in the blanks and following the instructions:

Right now I am feeling _________,
(insert name of the current emotion, usually fear)
and I am sensing in my body _____________,
(describe your current bodily sensations—name at least three),
because I am remembering __________,
(name the trauma by title only)—no details).
At the same time, I am looking around where I am now in ______,
(the actual current year),
here ____,
(name the place where you are)
and I can see_________,
(describe some of the things you see right now in this place),
and so I know_____,
(name the trauma, by title only, again)
is not happening now/anymore.

In my own therapeutic practice, I have found this concept of dual awareness to be very useful in helping clients who get "sucked into the vortex" (Levine, 1997) by triggers, their flashbacks and/or nightmares. They can be assisted to return them to the safety of the present moment. In addition I have found that other grounding work at the end helps ensure that the client is not leaving the therapy session in either a hyperaroused or semi-dissociated state. I usually utilize one, or a combination of three approaches: 1) guiding clients through a mindfulness meditation that uses their breath as an anchor; 2) guiding clients through a mindfulness or relaxation exercise followed by a having them physically ground their feet and legs on the floor. If time allows, I find it effective to guide clients through a visual imagery of having them growing roots into the centre of the earth and connect with the red healing energy of the earth; 3) use guided imagery to have clients create a sense of sacred space in the room by having them breath white, healing energy into every part of their body, and imagine that tensions and other overwhelming sensations in the body are being neutralized by the white light and then released with every exhalation.

A Sensorimotor Approach to Trauma Treatment

Ogden, et. al. utilize the concept of mindful awareness across the various therapeutic techniques used throughout the treatment process. They point out that bringing clients to a window of tolerance necessarily implies they will

slowly begin to develop mindful awareness and tolerance for uncomfortable sensations. They learn to do this instead of "numbing out, acting out, or avoidance of the sensations. Clients also "learn to identify early somatic precursors to hyperarosed or hyposaroused states and discriminate between sensations triggered by reminders of the trauma and those related to non-traumatic here-and-now experience...Learning how to sense and identify internal sensations such as feeling tense, cold, heavy, numb, or tingly can help clients recognize the precursors to traumatic arousal and plan alternative coping strategies." (Ogden et. al, 2006, p. 218). Ogden et. al. caution that an extremely destabilized client may not be able to tolerate mindful awareness of body sensations but may be helped to identify what movement feels good, i.e. pushing, standing, walking, etc.

The sensorimogtor approach can assist clients to differentiate between sensations, emotions, and cognitions. By learning to describe their emotions in a language that is "physical rather than emotional...One client was able to verbalize the somatic experience of her emotions this way: "I feel the sadness in a collapse in my chest that has an aching around my hart". Ogden, et. al also explain how sensations can also be confused with meaning, interpretation, and cognition", and provide the example of a client who is habitually triggered into a traumatic alarm response by everyday stimuli, who interprets this as the world being unsafe. To facilitate the distinction, the therapist can ask the client to become mindfully aware of how this belief is experienced in their body.

To further reduce the overwhelming experiences that get disorganized and confused in clients with PTSD, Ogden el al, also offer techniques to assist clients to differentiate between sensations felt internally, those perceived with the 5 senses, and through movement. I would like to share ways in which the sensorimotor therapeutic work has impacted on my own work with clients.

I have personally found it very useful to incorporate the concept of slowing down and differentiating sensations in my own practice. For example, I have assisted a client who is extremely dissociative, constantly operating at a cognitive level and numbing from her body, to begin to take a more curious stance in regard to discovering her body sensations. I have blended use of bieenergetic grounding techniques to thaw out this client's numbness in order to help her connect to her feet and legs. The slow paced sensorimotor and other somatic techniques offered by Rothschild have come in handy as a way to reduce her hyperausal, and/or increase the energy flow in her body when she experiences states of hypoarousal. Prior to using these techniques I often felt stuck when she either became so anxious that she wanted to leave, avoided coming to session, etc., or so hopeless that she could not shift from her cognitive belief that she did not have the capacity to heal. By incorporating these techniques I have felt more confident and grounded in the belief that we can shift the work when it starts to lose focus,

and eventually carry out very effective work that involves both bioenergetic and energy healing work of a deeper nature.

Ogden, et. al., make yet another interesting distinction between body resources at the core and periphery. That is, somatic resources aimed to foster awareness of the core of the body, i.e. centering, grounding, breathing, alignment, etc, "provide a sense of internal physical or psychological stability and therefore support autoregualation". Those resources that promote awareness and movement of the periphery, i.e. pushing away, reaching, locomotion, "tend to facilitate social skills and interactions with the world at large, and support the capacity for interactive regulation." (Ogden, et. al., 2006, p.22)

Phase 2 of the sensorimotor treatment approach outlined by Ogden, et. al., centers around "processing traumatic memories and restoring acts of triumph". Their focus is to help clients to accomplish the following:

> "overcome the traumatic imprints that dominate their lives, are the sensations, emotions, and actions that are not relevant to the demands of the present but are triggered by current events that keep reactivating old, trauma-based states of mind (Van der Kolk,2002, p.59). By identifying these imprints as they emerge in clients' organization of experience and helping them study, rather than react with trauma-related tendencies (dissociation, dysregulated arousal, and maladaptive defensive responses), the nonverbal traumatic residue can be resolved." (Ogden et. al, 2006, p.235)

Ogden et. al identify that "integration of all the dissociated components of the memory" is the primary goal of the second phase of treatment. This is based on the belief that symptoms will be significantly reduced as a result, thereby making it possible to manage triggers so that they no longer "hijack their thoughts, emotions, and body", thereby increasing the individual's capacity for daily functioning. Ogden, et. al provide a complete and detailed breakdown of therapeutic work towards integration in their excellent book, *Trauma and the Body: A Sensorimotor Approach to Psychotherapy*. Reviewing these techniques is beyond the scope of this paper, however, the authors eloquently summarize their meticulous approach:

> Because of the dysregulating nature of hyperarousal, the therapist endeavours to work slowly, through one arousal cycle at a time. When arousal is noted the client is instructed to become mindful of that sensation, until the nervous system begins to settle down. That is, one cycle of arousal, starting with a sensation or micro movement, processing through discharge or involuntary movement, and then the autonomic settling and resolution that brings arousal back into the window of tolerance. The arousal is metabolized, either through bodily discharge e.g. tingling, trembling, shaking) or mobilization and

demobilization of defensive responses. As the cycle comes to completion, another sliver of traumatic material is accessed if time allows in the therapy session, and the cycle is repeated." (Ogden, et. al, 2006, p.259)

It can be seen from this description that a cathartic energy release, is not the goal here, but rather, a slow, integrative process that evolves over time. Integration is further optimized by processing fragments of implicit memory (felt memories) and their disorganizing effects on the individual, clearly illustrated by Rothschild in an earlier section of this paper. The concepts and techniques to accomplish the integrative work that can be embarked on in phase 2 include: a slow pace, limiting the amount of information being processed, working at the edge of the window of tolerance, initiating new resources while working with a memory, mobilizing defenses leading to a sensory experience of triumph; finding other incomplete actions; sensorimotor sequencing of mobilizing defenses and orienting responses.

Because this paper is intended to present a comprehensive exploration of body-oriented approaches that can help stabilize and carry on the initial stages of trauma-focused healing work, in as safe a manner as possible, phase 3 of the sensorimotor treatment approach will not be elaborated on here. It will suffice to say that it's focus is to "empower clients to develop a life after trauma—a life no longer dominated by the shadow of traumatic events or their interruptions into ordinary or pleasurable experience" (Ogden et.al. p.268). It is designed to help clients make meaning of the trauma they had to endure in the past, and move forward with a new and improved sense of Self.

A cautionary note: some clients may be triggered or phobic to connecting to their bodies, and possibly even to the words associated with the body. Avoiding the words at the beginning of therapy may work for some clients, while for others, "providing a menu of words with which to label body sensations, learning to self-observe in order to decrease the sense of "being looked at" and normalizing somatic experience through psycho-education, or a brief illustrative anecdote that describe difficulties similar to theirs establishes comfort with sensorimotor approaches" (Ogden, et. al, 2006, p.211). In addition, a clear discussion with clients about the goals of incorporating somatic resource-building techniques may promote curiosity, interest, and hope. In my own experience, I have found that using somatic resource building techniques has assisted a client to shift from being utterly hopeless and suicidal to enthusiastic about attending weekly sessions that teach her to practice body-awareness in between-sessions and/or access this capacity during sessions when arousal levels get either too high or low.

Using The Body As A Resource for Healing: Discrete Use of Touch Therapeutic Approaches

I support Rothschild's assertion that it is extremely important to be judicious about the use of touch therapy with trauma survivors. Clients of the Type II(nR) category, may be especially vulnerable to being re-traumatized through use of touch, and it is imperative to be clear about when using such techniques will and will not be therapeutic. In my own experience of incorporating various techniques, including mindfulness, bioenergetics, and energy healing approaches, with this type of client, I have found it useful to also draw from the somatic and sensorimotor techniques offered by Rothschild (2000)and Ogden, et.al.(2006). That said, I am clear that my intuition is by far my biggest tool when assessing whether or not to engage in touch-oriented body work .

I believe that my intensive training in bioenergetics and energy healing has helped me tremendously in enhancing my capacity to connect to my natural inner source of wisdom, which can manifest itself in therapeutic intuition. Moreover, my personal mindfulness practice, combined with spiritual growth as a result of experientially learning how to conduct deep energy healing work, has cultivated in me a deeper appreciation of my commitment to sacred healing work. This has been rewarding to not only myself but also my clients, in *knowing* and *trusting*, at a deep level, that this work holds incredible potential for profound healing. Still, given the nature of the complex PTSD issues that some clients face, I use both bioenergetic and energy healing touch therapeutic work with much discretion. Actually, I have found it very useful to wait several months, or as long a it takes for clients to feel safe in the therapeutic relationship, before ever initiating this type of work. Effective work with such clients necessarily implies having a strong therapeutic alliance and connection.

With my limited experience with hands-on bioenergetic and energy healing work, I can humbly say that I have learned that for my complex PTSD clients of the Type II(nR) category, it can be comforting, nurturing, and healing. A client fitting this description, whom I have had the privilege of working with and learning from for over a year, has reported having experienced the combined body and energy work as a preferred mode of working with her traumatic past. This client has expressed being appreciative of the slow work towards developing mindful body awareness, and also of the careful and gradual work on processing/resolving snippets of traumatic material that organically emerge during some of our sessions. The following description of some of our work together may provide an understanding of this process:

While working with a client who is diagnosed with Dissociative Identity Disorder, I was able to help the client work through overwhelming anxiety through the use of mindfulness, followed by grounding, which in turn guided the work of having the client pay close awareness to the anxiety in the client's body. My intuition also guided me to ask the client if she would be able to tolerate me doing some deep energy healing work on the part of her body where she felt the anxiety was concentrated as a dense "ball". As I knew that this client had difficulty saying "no" herself (a result of many years of childhood sexual abuse), I assured her

that it would be to her advantage to assert herself with me if she did not feel o.k. about the hands-on work. The client insisted she felt the hands-on work was appropriate at that particular time and I proceeded to channel energy into the area by gently placing my left hand in that particular region. I continued to sporadically ask the client to let me know of what she was aware of throughout the channeling work, and the client was able to identify how the anxiety was acting as a defense to feeling her deep sadness/grief and to verbally expressing these emotions. Slowly, as the client began to notice how her anxiety shifted in her body, and as she experienced safety in having me be energetically connected with her, the client began to connect to the grief while in a dissociated state (the client suffers from DID and so switched to an alter). However, once her core Self returned she was able to identify having been co-conscious while her alter expressed her grief. She expressed that this experience had deeply shifted something in her body which made her feel calm and more at peace.

On a subsequent session, and through the use of an anchoring technique (the client's imaginary "sacred place") to lower the client's arousal, the client was able to connect to some of the sadness and grief of her own core Self's sadness/grief, as well as that of her alters. Utilizing the anchoring technique offered by Rothschild, the client was able to clearly see, feel, and get an experience of being in her "sacred place", a place she often dissociated to when she was a child. It's important to note here that I did not ask her to visualize her alters in her "sacred place", however, the process of being deeply connected to herself and her body while I channeled healing energy into her heart charka, appeared to facilitate this spontaneous process. The client was able to see her alters waiting for her (her core Self) to embrace them and was able to release some of the sadness while feeling the emotions in a calm, and deeply supported manner. The client expressed that this experience had been "a breakthrough" as she became acutely aware, on a sensory level, about the extent to which she had been "denying" her alters, and hence causing "chaos" within the entire system (a term utilized to map the existence and function of each alter in a person with D.I.D.). After the body work was completed the client was able to shed a few tears about how sad she felt in her core Self for having done this to her parts, and was able to deeply connect with the importance of accepting and loving her alters. This is extremely important as it coincides with the "integration" process that is recommended in work with D.I.D. clients.

Choosing Trauma-Focused Treatment Approaches

Any competent, skilled, well recognized therapist knows that when it comes to working with severely traumatized clients, there will be many challenges resulting from the perpetual traumatic reactions and personality issues resulting from abuse incurred and defended by the body and mind over the developmental years. These challenges, if not dealt effectively by the therapist, can easily derail and/or sabotage the healing progress. I believe that to provide a comprehensive approach to healing such complex issues, we need to access all the tools at our disposal, those we already have and those that are emerging with more recent

focus on somatic therapy. We need practical tools, derived from simple, wise, and powerful sources found in nature, and spiritual healing practices, as well as those discovered via the scientific method which comprise most of what we already know.

I share Babette Rothschild's concern over the apparent competition among therapeutic approaches that claim sole ownership over best-practices in trauma-focused therapy. This indeed does a disservice to our clients. In my experience as counsellor/therapist I have relied on various disciplines and modalities, including: psychology, social work, alternative spiritual practices, psychodynamically and cognitive-behavioral-oriented approaches, brief, feminist, narrative, expressive arts, and various trauma focused approaches that utilize a blend of various of the approaches mentioned here. They have all been helpful to me and to some, if not all of my clients. As such, I believe the following statement captures my opinion:

> "Each available therapy helps some clients, and each of them also fails at times. Every modality has strengths as well as weaknesses. Just as there is no one medication to treat anxiety or depression, there is no one-size-fits-all trauma therapy. In fact, sometimes it is the therapeutic relationship, not any technique or model, that is the primary force for healing trauma....Perhaps a better basis for judging the success or failure of a method might be to trust the client's body awareness and symptom profile: "Has this helped you? Are you calmer, more contained, better functioning? Okay, let's continue." "This isn't helping? You feel worse, more unstable, less able to handle your daily life? Okay, let's try something else." As previously stated, the safest trauma therapy comprises several models, so the therapy can be adapted to the specific needs of the client." (Rothschild, 2000, p.150-1)

In regards to the basic necessary elements of trauma-focused practice she adds:

> "All of the trauma treatment modalities, though have two things in common: They are all highly structured, and they are all highly directive. Each method involves precise protocol that must be followed to reach resolution of traumatic memories. This requires that the therapist be directive, steering the protocol rather than following the client's process. It appears that this commonality is no accident. Those working with trauma from divergent disciplines—demonstrate agreement that working with trauma requires structure and direction. This makes sense as following the client's process without intervention usually results in either avoidance of traumatic memories or becoming overwhelmed by them." (Rothschild, 2000, p.150-1)

Though I disagree with any rigid statement about therapy having to be guided by the therapist at all times, I do agree that a considerable amount of structure in the

treatment and direction on the therapist's part is a requirement. When I began working with female survivors of extreme violence, I remained very loyal to my belief that "the client and not the therapist is the expert of the client's life, and that as a feminist therapist committed to helping women in their empowerment, my job was above all, to help the woman feel validated and not pathologized. I still loyalty to these values, however, my clients and my training have taught me that staying with them in their process,-- by this I mean mostly listening, validating, empowering, and hoping that solidarity, pure empathy, and impeccable attunement, are not sufficient to help these clients work through and resolve their trauma.

Having said this, I would like to caution therapists who find the scientific knowledge-base on trauma to be the only valuable avenue. As stated above, I believe that the psychophysiological field has crucial information to contribute to the understanding and treatment of trauma, however, it is not, in my opinion, absolutely necessary to follow a strictly scientific and systematic approach in its treatment. There will be much to lose by strictly following a scientific approach at the expense of intuitive attunement and connection with clients and sacrificing the therapeutic alliance. This does not mean that I promote becoming enmeshed with the client, or losing sight of one's risk of becoming vicariously traumatized. I feel that for us therapists our intuition is our strongest tool. This tool is necessary when learning the valuable skill of oscillate between engaging in highly structured and directive work, and when it makes more sense to stay with the client where they are at in their process, trusting that clients really have the ultimate wisdom when it comes to their own healing. Perhaps a quote from Levine will clarify this point further:

> "Held within the symptoms of trauma are the very energies, potentials, and resources necessary for their constructive transformation. The creative healing process can be blocked in a number of ways—by using drugs to suppress symptoms, by overemphasizing adjustment or control, or by denial or invalidation of feelings and sensations." (Levine, 1997, p.37)

I would like to make another key point in advocating for clients here. Though I acknowledge the importance and value of my interventions and therapeutic connection with clients with whom I have only been able to work briefly (due to lack of government funding for public sector long-term work with trauma survivors), I have always known that my clients require and deserve the long-term therapy that allows for pacing of safe and effective therapeutic work to meet clear therapeutic goals at every stage in a traumatized client's healing process. It is primarily for this reason that I have decided to become a private therapist. This, of course, does not, however, solve the issue of making therapy affordable for clients whose lives are compounded by poverty and other marginalized realities. One of the best things about our health care system is that if a person is suffering from a life-threatening illness the system, for the most part, prioritizes

such a patent's care and subsidizes it. Trauma survivors are, in my opinion, suffering from a chronic, life-threatening condition and it is very unfortunate and unfair that they do not receive the same level of access to mental health care.

In my view choosing therapeutic modalities and/or techniques is a very personal decision, given each therapist's discipline, specialized training, level of interest in one approach over another, and proficiency with any given approach. However, one must put aside all biases when it comes to being committed and dedicated to take on the level of patience, endurance, and challenge one faces with the realization that helping to heal severely traumatized clients will require tapping into a variety of personal and professional resources. I have heard it said time and time again by colleagues, including experience and reputable clinicians, "working with trauma is very difficult, challenging work, and it is admirable that some people are committed to doing it". If one commits to it then one must be also willing to take a humble stance and embrace the ongoing learning process.

Some Thoughts On Self -Care

Nearly all the books I have read on the treatment of trauma have mentioned that the challenging task of working through transference and coutnertransference with clients is not only arduous, but necessary in order to help the client experience a corrective experience. In my own experience, clients with very demanding needs, which for the schizoid, borderline, and complex PTSD (often, all three are present) client can mean strong transferences of feelings they experienced with a childhood caregiver and/or perpetrator onto me. These projections are based on their unconscious suspicion that I may hurt them in the following ways: abandon, reject, not love/regard them as worthy unless they are "perfect clients", and possibly even be perceived as untrusting or dangerous. Having to address all of these transferential reactions, as well as my countertransferential reactions stemming from my own personal issues, is sometimes exhausting work to say the least. I have found clinical supervision, peer supervision, my own therapy, and reading books on this topic to be a great source of comfort and have experienced myself as more grounded, invigorated and confident after reaching out for such resources.

By accessing the clinical resources just mentioned I have learned a great deal about myself and my ethical obligation to engage in self-care activities that will help me separate my own life and needs from those of my clients by creating healthy boundaries. By reading about the common countertransferential responses of therapists who work with D.I.D. clients, I have also learned that as a well intentioned therapist, my own feelings towards the client, for example, one's unconscious like or "favoritism" a particular alter over another, when working with a person with D.I.D., can have serous implications for building collaboration between the alters (necessary for integration) and a for the therapeutic alliance (Oxnam, 2005). In his book Diagnosis and Treatment of Multiple Personality

Disorder (1989), Frank Putnam brought me much needed relief as he addressed how clients' resistance to getting on with the sometimes intolerable trauma-focused work with their multiple alters often causes the following disruptions in therapy:

> "Multiples seem to teeter continuously on the brink of total disaster. Every improvement is followed by a relapse. Hostile alters threaten suicide, internal or external homicide, and assorted other catastrophes...The ability to tolerate a high degree of background noise is an essential attribute for therapists working with MPD (now known as D.I.D.) patients." (Putnam, 1989, pp. 160-1)

Putnam addresses some of the common countertransferntial reactions to these common types of transferences, including: the fear of losing one's first MPD (or DID) client, resulting in a blurring of boundaries that therapists are accustomed to applying to their other clients. In my case, the sole act of reading about these common transference and countertransference reactions brought me such relief, that I immediately felt a sense of empowerment in knowing that my countertransferential reactions were quite normal. Furthermore, I was relieved to learn that many other clients with DID experience some of the same crises and therefore not a reflection of my lack of skills and/or competence. Although I still treat every reported suicidal episode with the same level of care, I no longer completely lose my boundaries when making myself available or "on call". Instead, it helps me to know that this is a common form of resistance to the work which indicates that one or more alters are experiencing resistance due to overwhelming emotions. In fact, wanting to learn how to prevent my DID clients and their alters from becoming overwhelmed by the therapy, has been perhaps the biggest impetus for choosing the topic of in this paper.

The topic of excessive empathy is worth mentioning. As it can lead to burn-out or compassion fatigue. As has been presented above, there is a growing and exciting field in trauma-focused therapeutic work, however, not much has been written about how the therapist's own body, mind, and sprit can be impacted. In her book, Help for the Helper: Self-Care Strategies for Managing Burn-Out and Stress (2006) , Babette Rothschild provides useful information that assists therapists to track and monitor their empathic reactions so that they do not become hazardous to either the therapist or client. Included In this resource is useful information about the benefits of making a therapist's unconscious mirroring of the client conscious to the therapist. The aim is for the therapist to become mindfully aware during sessions about how they unconsciously mirror their client's posturing to prevent therapists from experiencing their clients' emotions via a somatic experience. I have already started to practice this new method of protecting myself from my own empathy, -- it is remarkable to learn that I indeed do mimic some of my clients' postures and movements, and thereby take on my client's feelings! It's good to become mindfully aware of this and thereby be able to stop this from happening.

In regard to vicarious trauma, one of the best methods I have found is to talk to a clinical supervisor about the impact of the horrible traumatic events that have been disclosed to me. Also limiting unnecessary exposure to TV. films, or other violence-related media exposure has been a wise move if I've had too much exposure to vicariously traumatizing client narratives. Instead, I have found it very invigorating to engage in fun, creative activities that allows my inner child to come out and play.

Conclusion

Researching and writing this paper has assisted me to gain some clarity on how to move forward to develop the safest, most effective ways to proceed through the initial phase of trauma-focused body and energy work. I am grateful for the insights, techniques, and awareness of my own Self as therapist that this opportunity has afforded me. My gratitude is extended to John Went for sharing his wisdom and vast knowledge, while providing me and my peers with an extraordinary learning opportunity via the psychotherapy training I have completed with The Integral Healing Centre of Toronto. I am also grateful to my peers with whom I had the privilege of entering into life-transformative experiential learning opportunity.

The themes covered in this paper are by no means exhaustive when it comes to what one needs to know when doing this type of work. I have only delved into areas that are of most relevance in my own practice at the moment. I encourage whoever reads this paper to pursue further knowledge in this vast and growing field, and hopefully discover themselves the great rewards of working with severely traumatized clients. It is exciting to watch clients begin to shift out of their hopeless states and cyclical maladaptive patterns and begin to discover their true, competent, lovable selves. It is life-affirming to feel the joy of knowing that the profound healing of another being can be the reward of finding meaning and purpose in one's life journey.

Appendix A - PTSD

DSM-IV DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

A. The person has been exposed to a traumatic event in which both of the following were present:
   1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   2. The person's response involved intense fear, helplessness, or horror

DSM-IV DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
   1. Recurrent and intrusive distressing recollections of the event, including images, thoughts and perceptions
   2. Recurrent distressing dreams of the event
   3. Acting or feeling as if the traumatic event were recurring
   4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

DSM-IV DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

C. Avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- Efforts to avoid thoughts, feelings or conversations associated with the trauma
- Efforts to avoid activities, places, or people that arouse recollections of the trauma
- Inability to recall an important aspect of the trauma
- Markedly diminished interest or participation in significant activities
- Feeling of detachment or estrangement from others
- Restricted range of affect (e.g. unable to have loving feelings)
- Sense of a foreshortened future (e.g. does not expect to have a normal life span)

DSM-IV DIAGNOSTIC CRITERIA FOR POST-TRAUMATIC STRESS DISORDER (PTSD)

D. Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following:

- Difficulty falling or staying asleep
- Irritability or outbursts of anger
- Difficulty concentrating
- Hyper-vigilance
- Exaggerated startle response

Appendix B – Complex PTSD

COMPLEX POST-TRAUMATIC STRESS DISORDER

(Not a formally accepted Diagnosis in the DSM)

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.

2. Alterations in affect regulation, including:

- persistent dysphoria
- chronic suicidal preoccupation, self-injury
- explosive or extremely inhibited anger
- compulsive or extremely uninhibited sexuality

COMPLEX POST-TRAUMATIC STRESS DISORDER

(Not a formally accepted Diagnosis in the DSM)

3. Alterations in consciousness, including:

- amnesia or hyperamnesia for traumatic events
- transient dissociative episodes
- depersonalization/ derealization
- reliving experiences

*4. Alterations in self-perception, including:

- sense of helplessness or paralysis of initiative
- shame, guilt and self-blame
- sense of defilement or stigma
- sense of complete difference from others

COMPLEX POST-TRAUMATIC STRESS DISORDER

(Not a formally accepted Diagnosis in the DSM)

5. Alterations in perception of perpetrator, including:

   preoccupation with relationship with perpetrator

- unrealistic attribution of power to perpetrator
- idealization of paradoxical gratitude
- sense of special or supernatural relationship
- acceptance of belief system or rationalizations of perpetrator

COMPLEX POST-TRAUMATIC STRESS DISORDER

(Not a formally accepted Diagnosis in the DSM)

6. **Alteration in relation with others including:**

- **Isolation and withdrawal**
- **Disruption in intimate relationship**
- **Repeated search for a rescuer**
- **Persistent distrust**
- **Repeated failures of self-protection**

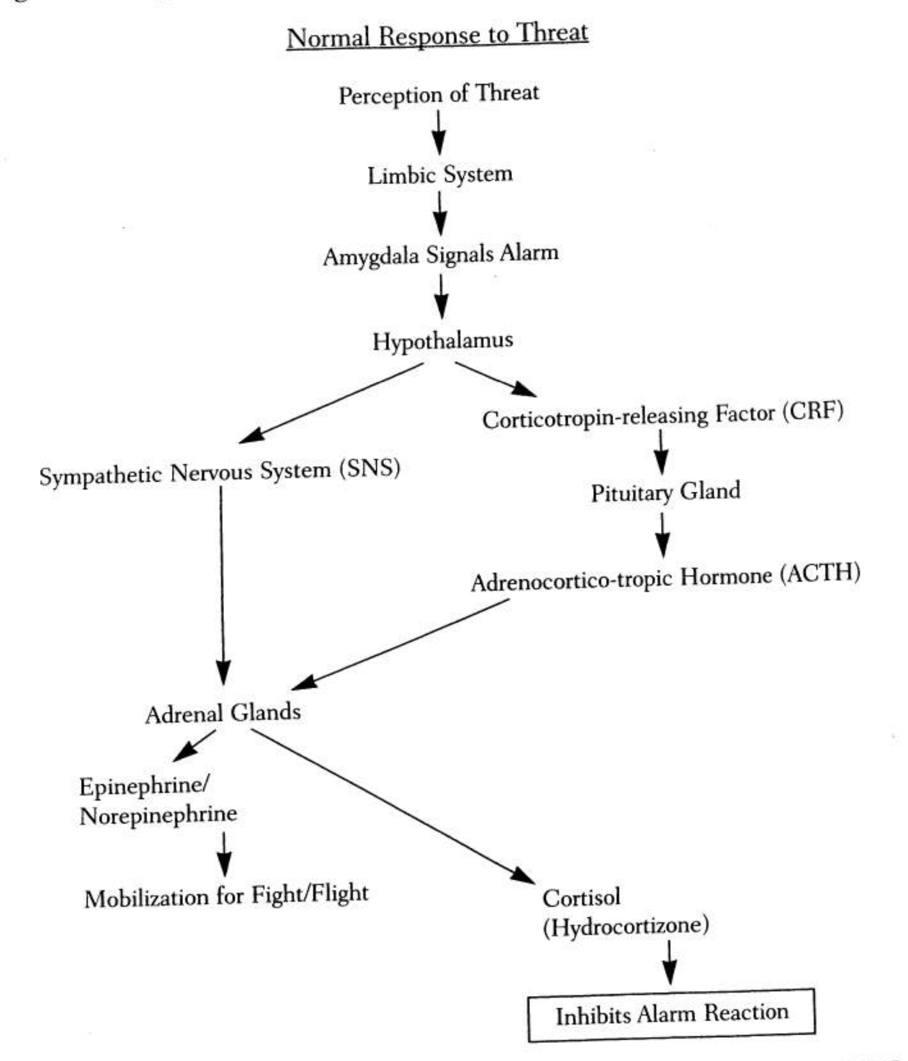
7. **Alterations in systems of meaning, including:**

- **Loss of sustaining faith**
- **Sense of hopelessness and despair**

(adapted from Judith Lewis Herman, Complex PTSD in "Trauma and Recovery" 1991)

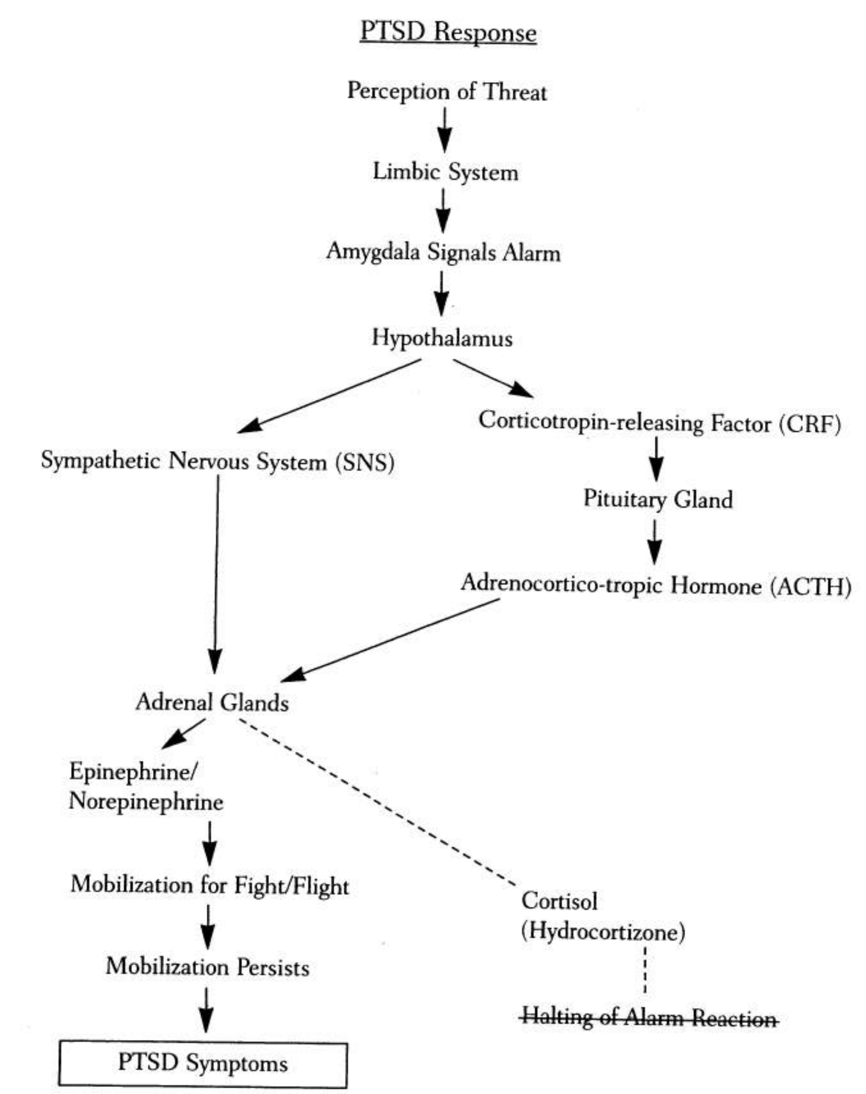
Appendix Bi and Bii – HPaxis

Figure 1.1. Hypothalamic-pituitary-adrenal (HPA) axis.



could be imminent, then the body will freeze. In this state the victim of trauma enters an altered reality. Time slows down and there is no fear or pain. In this state, if harm or death do occur, the pain is not felt as intensely. People who have fallen from great heights, or been mauled by animals and survived, report just such a reaction. The freeze response might also increase chances of survival. If the cause is an attack by man or beast, the attacker may lose interest once the prey has gone dead, as a cat will lose interest in a lifeless mouse.

Figure 1.2. Hypothalamic-pituitary-adrenal (HPA) axis.



(*Charlie lost consciousness during the dog attack, and when later confronted by contact with a dog he became paralyzed. Both are forms of freezing responses.*)

It is important to understand that these limbic system/ANS responses are instantaneous, instinctive responses to perceived threat. They are not chosen by thoughtful consideration. Many who have suffered trauma feel much guilt and shame for freezing or "going dead" and not doing more to protect themselves or

Appendix C – Borderline Personality Disorder

Diagnostic Criteria for Borderline Personality Disorder (DSM)

A pervasive pattern of instability of interpersonal elationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment.
   Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5.

2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

3. Identity disturbance: markedly and persistently unstable self-image or sense of self

4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).
   Note: Do not include suicidal or self-mutilating behaviour covered in criterion 5

5. Recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

Diagnostic Criteria for Borderline Personality Disorder

6 Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

7 Chronic feelings of emptiness

8 Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)

9 Transient, stress-related paranoid ideation or severe dissociative symptoms

Adapted from the DSM-IV, American Psychiatric Association

CHARACTER DEVELOPMENT IS BASED ON 3 VARIABLES:

- Innate needs
- The environments capacity to be attuned and responsive to these needs
- The ability to cope with and process environmental failures in attunement to these needs

DSM-IV Diagnostic Criteria for BPD

- Frantic efforts to avoid real or imagined abandonment
- A pattern of intense and unstable interpersonal relationships
- identity disturbances or problems with sense of self
- impulsivity that is potentially self-damaging

DSM-IV Diagnostic Criteria for BPD

- Recurrent suicidal or parasuicidal behaviour
- Affective instability
- Chronic feelings of emptiness
- Inappropriate intense or uncontrollable anger
- Transient stress-related paranoid ideation or severe dissociative symptoms

Appendix D – Trauma Vortex & Healing Vortex

Figure 2
A Breach in the Stimulus Barrier
Formation of the Trauma Vortex

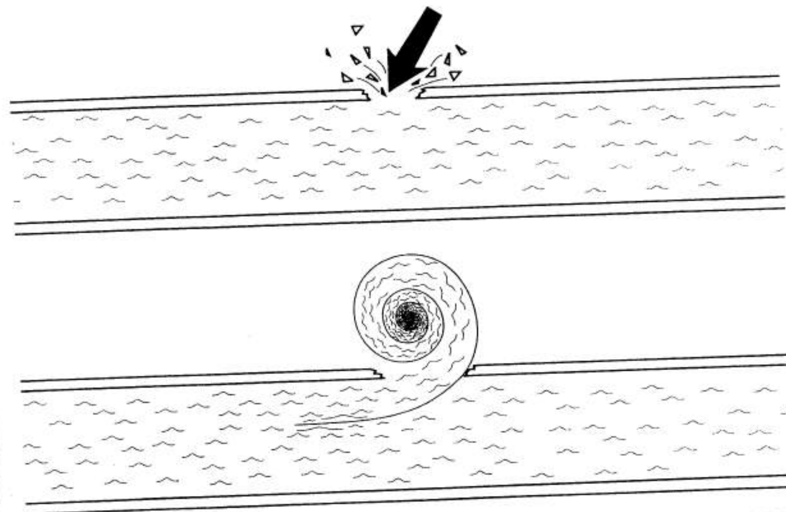
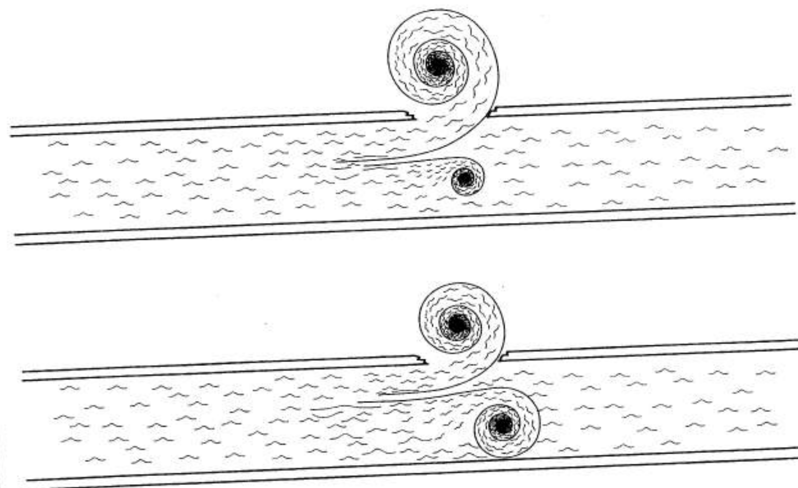


Figure 3
Formation of the Healing (Counter) Vortex



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