

Body Psychotherapy

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Body psychotherapy without touch: applications for trauma therapy

Babette Rothschild

Introduction

Memory of traumatic events differs from memory of other events in that it is often non-verbal, somatic, implicit memory. This makes body psychotherapy a natural for helping to integrate traumatic experiences. However, many traumatised clients – especially those who have suffered at the hands of others – cannot be touched without becoming overwhelmed or going dead in their bodies. This presents a unique challenge to the psychotherapist and the body psychotherapist: how to integrate body experiences without touch? This chapter will offer both theory for understanding and techniques towards solving this dilemma.

Psychotherapists and body psychotherapists have much they can learn from each other. The bias of each group is actually its unique contribution to the field of psychotherapy. Psychotherapists tend to emphasise cognitive understanding and integration. Though some may pay attention – more or less – to the body, it is the mind that is their focus. Body psychotherapists, on the other hand, tend to be most interested in the integration of bodily reactions and emotions. Though the body psychotherapist considers cognitive aspects, it is the body that is the usual focal point.

The study of posttraumatic stress disorder (PTSD) is forcing a long overdue meeting of these two orientations. This is occurring because PTSD has become a well-known psychiatric diagnosis that has recognised somatic (most notably hyperarousal in the autonomic nervous system (ANS)) as well as cognitive components (American Psychiatric Association (APA) 1994). Inspired by the phenomenon of PTSD, body psychotherapists are being challenged to pay more attention to what is happening in the mind, increasing skills in cognitive integration. Simultaneously, the psychotherapist is being challenged to pay more attention to the body, increasing skills in mind/body integration (Rothschild 2000).

This juncture poses difficulties for all concerned. The psychotherapist may shy away from paying attention to the body for fear that touch will become an issue. The body psychotherapist who employs touch as a usual tool may find

that the symptoms of some clients – particularly those who were traumatised by assault, rape or abuse – will worsen with touch. The possibility that somatic symptoms can be addressed without touch has not often been explored.

An abbreviated glossary of relevant terms

This short list of relevant terms (Rothschild 1998) should lay a useful foundation for the rest of this chapter:

The *autonomic nervous system (ANS)* is the division of the body's nervous system that regulates viscera and smooth muscles: heart and circulatory system, kidneys, lungs, bladder, bowel, pupils, etc. There are two branches:

- The *sympathetic nervous system (SNS)* is primarily aroused in states of stress, both positive and negative. Signs of SNS arousal include increased heart rate and respiration, cold and pale skin, dilated pupils, elevated blood pressure.
- The *parasympathetic nervous system (PNS)* is primarily aroused in states of rest and relaxation. Signs of PNS arousal include decreased heart rate and respiration, warm and flushed skin, normally reactive pupils, lowered blood pressure.

These two branches usually function in balance with each other: when one is activated, the other is suppressed. Persistent extreme activation in one or both branches is referred to as *hyperarousal*.

Stress can result from any emotional or physical demand (positive or negative). It was first recognised by Hans Selye (1956) through the observation of 'evidence of adrenal stimulation, shrinkage of lymphatic organs, gastrointestinal ulcers, and loss of body weight with characteristic alterations in the chemical composition of the body.' Stress causes activation in the SNS. Generally regarded as a response to a negative experience, stress can also result from positive experiences: marriage, job change, moving, sex, etc. The most extreme form of negative stress is *traumatic stress*.

Traumatic stress is a psychobiological reaction to a *traumatic event* (i.e. war, disaster, car accident, rape, assault, torture, surgery, molestation, loss of significant other, etc.). Occurring in the face of threat to life and/or limb, traumatic stress causes hyperarousal of the ANS and elicits the survival responses of fight, flight and/or freeze. It is necessary to survival.

Posttraumatic stress (PTS) is traumatic stress that persists after (post) a traumatic incident when it has not been relieved through successful fight or flight, or other natural or therapeutic means. PTS may be characterised by

periodic symptoms of hyperarousal in the ANS, flashbacks and/or dissociation. It does not disrupt general functioning.

Posttraumatic Stress Disorder (PTSD) is the result of accumulated post-traumatic stress, resulting from one or more traumatic events, that is of sufficient severity and constancy to decrease a person's ability to function in his life. PTSD is characterised, in part, by chronic symptoms of ANS hyperarousal (including sleep disturbance, lack of concentration, hypervigilance, exaggerated startle reflex) and continued activation of the survival responses of fight, flight and/or freeze. Hyperarousal indicates that the traumatic event is being repeatedly remembered in mind and/or body. In addition there will be avoidance of environmental stimuli associated with the trauma (*triggers*). PTSD is considered *acute* if the duration of symptoms is less than three months, *chronic* if the duration of symptoms is three months or more. *Delayed onset* of PTSD is recognised when symptoms arise at least six months after the traumatic event, including reactions in adulthood to an event that occurred in childhood (APA 1994).

Dissociation is a psychological state where the memory of an event is divided into parts. Recall of all of the parts as a whole is not accessible to consciousness at any one time. Instead, the event might be remembered as disjointed elements or, seemingly, not at all.

A *flashback* is a common, though not always present, symptom of PTSD. 'In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment' (APA 1994: 424). During a flashback the ANS prepares the body for fight/flight/freeze as if the event were occurring now. Flashbacks can be visual, auditory, behavioral and/or tactile.

The extreme somatic consequences of trauma

While any emotional response to a life event affects the body, trauma does so to the utmost. During a traumatic incident the brain's limbic system uses hormones to signal an alarm to the ANS. The ANS responds to this signal by activating the SNS to its most extreme arousal: preparation for fight and/or flight. Blood flows away from the skin and viscera and into the muscles for quick movement. Heart rate, respiration and blood pressure all rise to meet the needs of muscles for more oxygen. The eyes dilate to accommodate sharper sight. All of these elements of SNS arousal are necessary to respond to the threat. When fight or flight are not possible or have not been successful, the limbic system may further signal the ANS to *simultaneously* activate the PNS. The SNS continues its extreme arousal while the action of the body

freezes in place, the muscles becoming either slack like a mouse caught by a cat or stiff like a deer caught in headlights (Gallup 1977). The resulting internal strain is something similar to putting a car's accelerator to the floor while holding tight on the brake. During a freezing episode time slows down and body sensations and emotions are numbed; it is a kind of dissociation. As freezing only occurs when the threat is extreme and escape is impossible, these reactions make perfect sense. People who have survived mauling by animals or falls from great heights report that this kind of dissociation reduces the physical pain and emotional terror during such experiences.

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

As a survival mechanism freezing is excellent – witness the survival of our clients in that they are able to walk into our offices. However, freezing exacts a higher price in the wake of the traumatic incident than the responses of fight and flight. As a form of dissociation, freezing during a traumatic event is a major predictor of who develops PTSD (Bremner et al. 1992; Classen, Koopman and Spiegel 1993). People who have frozen during traumatic incidents and survived appear to have a greater difficulty coming to terms with their trauma. Many are plagued by symptoms of PTS or PTSD. Somatic symptoms abound as the hyperarousal in both SNS and PNS persist chronically, or are easily set in motion by environmental triggers. It is these people who have the most difficulty with psychotherapeutic touch.

Limitations of touch when working with trauma

While clients with little or no posttraumatic stress in their bodies may respond well to touch, there can be problems with clients who have suffered greater and lesser degrees of trauma, especially when those traumas were sustained at the hands of humans. There are at least two mechanisms underlying a client's inability to work with touch. The first is dependent on the type of trauma and the possibility that touch is a direct trigger to the memory of traumatic events. This includes, but is not limited to, situations where there is danger that the touching therapist could be perceived as the/a touching (sexual, violent) perpetrator. It is to both the client's and the therapist's advantage to avoid this situation. A therapist who becomes perceived as a perpetrator is lost as an ally in the therapeutic process. Time and again clients decompensate and/or quit therapy where this confusion has occurred.

A second mechanism influencing a client's touch tolerance involves the effect of touch on the nervous system. When PTS has accumulated to the point that an individual's hyperarousal is already 'near the top', touch could send that arousal soaring over a tolerable/containable threshold. If in doubt, it is better to hold off until the client is in a calmer state. This is not to deny that sometimes touch can be calming, but it is a challenge to predict or know

the difference. The best expert on whether touch is calming or not is the client. Asking the client frequently about her reaction – ‘Are you feeling calmer, more present, more grounded?’ or ‘Are you feeling more anxious, more distant, cut off?’ – should help guide both therapist and client.

Some may question whether touch must only be used when it is calming; can it also be employed in a useful manner to provoke trauma processes for working through of issues? It can be, but it is not always a wise choice. Provoking an individual with PTS or PTSD is not a good idea. It is important to regard the nervous system of such individuals as already highly provoked, actually over-provoked. As such it is more practical to work to *reduce* the provocation in the system rather than to increase it.

A useful analogy is to liken the person with PTSD to a pressure cooker. The unresolved trauma creates a tremendous amount of pressure both in the body and in the mind in the form of ANS hyperarousal. With the modern pressure cooker, 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.

Rothschild 2000

What is body memory?

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

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

don't have to learn it ever again. Those patterns of movement are stored forever in the brain.

The body also remembers traumatic events. The body sensations that constitute emotions (i.e. terror) and physical states (i.e. pain or ANS arousal) and the patterns that comprise movements (i.e. fight, flight, freeze) are all recorded in the brain. Sometimes the corresponding explicit elements – the facts of the situation, a description of the events, etc. – are simultaneously recorded, sometimes they are not (Rothschild 2000).

Traumatic memory versus memory of other events

The amygdala and hippocampus

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

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

Understanding the importance of the hippocampus becomes clearer when looking at what can happen to memory during a traumatic threat. When the arousal in the ANS becomes very high, the activity of the hippocampus becomes suppressed by the wealth of stress hormones that are released. When that happens, its usual function of lending context to a memory is not possible. The result may be that the traumatic event is prevented from becoming a 'memory' in the normal sense of the word – a piece of information about oneself that lies clearly in the past. What can occur instead is that the 'memory', unanchored in time, seems to float freely, often invading the present. It is this mechanism that is behind the PTSD symptom of 'flashback' – episodes of reliving the trauma as if it is happening now.

Dissociated elements of experience

Memory of any event is made up of the components of that experience. Peter Levine's SIBAM model (1992) is a useful way to conceptualise this. This model was developed in an effort to understand dissociation of memory and is useful for understanding memory in general. Levine has identified five major elements – sensations, images, behaviours, affects and meanings – common to any experience. Usual memories of non-traumatic events hold all of these elements intact. Recall triggered by one of the elements usually elicits the others. This is a common experience: remember the last time you were reminded of a pleasant time in your life by the smell from a bakery or a particular song. This kind of memory recall happens from time to time to nearly everyone.

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

The most troublesome traumatic memories are those that involve body sensations and little else. Individuals plagued with anxiety and panic attacks are examples of this. In such cases, the body sensations associated to the traumatic memory are intact, but the other elements, particularly the cognitive aspects (facts, narrative, time and space context) that could help the individual to make sense of the memories appear lost. Working with implicit, trauma-based sensations in the absence of a trauma narrative can be difficult. The explicit memory may or may not emerge. In such cases it will sometimes be necessary to find ways to ease the symptoms and/or increase their containment as the origin might never be known.

Using the body to integrate traumatic experience

Within the confines of this chapter it is not possible to describe all possible techniques for non-touch body work with trauma. What follows is a selection of those which are the most usefully adaptable within any framework of psychotherapy or body psychotherapy. What is important to remember, though, is not to depend too heavily on any one tool or technique. The safest trauma therapy is that which is adapted to the individual needs of the client. Never expect the same technique to have the same result with two clients. Having several tools – body oriented as well as cognitive – at your disposal is

the best way to assure your clients of productive therapy (Rothschild 2000).

This section includes three case example excerpts from *The Body Remembers: The Psychophysiology of Trauma and Trauma Treatment* (Rothschild 2000). They will help to illustrate applications of non-touch body techniques with trauma work. In addition, a complete session transcript, not previously published, follows at the end of this section. For the sake of protecting privacy and confidentiality, the cases presented are actually composites of several cases. In each instance the basic principles and thrust of the therapy being presented has been maintained.

Body awareness

Simple body awareness is the single best foundation for non-touch body work with PTS and PTSD. The use of body awareness as a means to health and enlightenment has roots that reach all the way back to the Eastern practices of yoga and meditation. The first use of body awareness as a tool in Western psychotherapy comes from the early days of Gestalt therapy (Perls 1942). For the purposes of this chapter, body awareness is defined as 'the precise, subjective consciousness of body sensations arising from stimuli that originate both outside and inside the body' (Rothschild 2000). In trauma therapy, the client's ability to identify and name somatic sensations will help the process immensely. This is not to say that individuals with no sense of their bodies will be unable to come to grips with a traumatic past. However, having or developing body awareness will facilitate the task.

Body awareness furthers trauma therapy in many ways. First, it supplies a much needed gauge to evaluate how the client is handling the therapy overall, and each intervention in particular. Second, body awareness points the way to troublesome body sensations that may have roots in the traumatic incident being addressed. Third, focusing on body sensations provides a necessary link to the present: body awareness is a current-time activity. Body sensations can be remembered or imagined from the past, but they can only be *felt* in the present. As such, body awareness can also be called upon as a tool of containment.

Angie

Angie was trying to stay away from her abusive husband. Sometimes he would show up where she was staying and she would go with him. It wasn't until later that she realised she had made a mistake. For her it was as though she entered an altered state. The fact that she couldn't control her behaviour, let alone describe what that state felt like, disturbed her immensely; she felt stupid and ashamed. Body awareness was difficult, generally, for Angie, but despite some anxiety, she was willing to try. I decided not to ask her about her

body specifically, as she could quickly become frustrated when she did not produce the 'right' answer. Instead I asked, 'Can you feel the chair under your buttocks?' That she could feel. I ventured, 'What does it feel like?' She was able to describe how the consistency of the cushion felt, as well as that the chair was unsteady because one leg was slightly shorter than the others. 'Do you feel more anxious, less anxious, or the same as when you arrived?' She felt slightly less anxious. So far, so good; I could dare a bit more. 'You can feel the chair under you now. Do you think that when your husband is around, you would be able to feel the chair?' Her interest increased as she answered the question, 'No, I don't think I could. Actually, I don't think I can feel anything when I get around him.' For the first time she could describe an aspect of her altered state: the absence of sensation. Already, via this short introduction to her body, it began to make sense to Angie that if she couldn't feel anything in the presence of her husband she would easily acquiesce. This was a microstep on the road to helping her gain control over her life (Rothschild 2000: 104).

Working with touch with Angie is not possible as she has been so traumatised by it. Body awareness was the primary tool for helping her to identify her dissociation. Some of the additional steps will involve increasing her body awareness and her muscle tone (see below). Angie will need to feel her body as strong in order to be able to eventually say 'no' to her husband. At a future point, becoming trained in self-defense will be a good idea.

Working with movement

Movement can also be a useful non-touch tool for resolving traumatic memories. It should be used with caution as its use can quickly accelerate contact with traumatic memories – sometimes overwhelming the client. Nevertheless, when it is timely, working with movement – particularly defensive movement – can greatly facilitate the process. Slow replication of movements that were used for protection during the traumatic incident (cowering, crouching, hiding, rolling) as well as training of movements that might have been more useful (running, pushing, kicking) can be very powerful. Work with movement must be done with particular caution. Careful attention with an eye to gauging the client's reaction (ANS arousal) is necessary each step of the way. If taken prematurely, too quickly, or in too big bites there is the risk of overwhelming the client or triggering an unproductive flashback.

Daniel

Daniel had suffered anxiety since surviving a big earthquake. He was hyper-vigilant, sleeping poorly and even having trouble bathing. He felt he must be always at the ready for the next quake. As he talked I noticed a dissonance in his posture. He appeared to be leaning back comfortably in his chair, but his

feet were placed on the floor in a manner suggestive that he was preparing to bolt. When I pointed this out to him he agreed that he was not able to relax at any time; he was always preparing to dive under the nearest table or run to the nearest doorway for protection. In addition, right at that moment, his heart rate was elevated and his hands were sweaty. I asked him if he had practised any of these defensive manoeuvres. He had not. I suggested that he do so now, following the impulse in his already defensively positioned feet. He did, bolting toward my office door. He opened it and crouched in the doorway. I encouraged him to repeat that movement several times – chair to doorway to crouch. After three practices I inquired as to his heart rate and hand moisture. Both were normalised. I encouraged Daniel to continue practising at home and at work, finding the best routes to safety. By the next week his constant vigilance had eased considerably, as he had by then anchored in his body the defensive moves necessary to reach protection during an earthquake (Rothschild 2000: 89).

Using simple body awareness and following behavioral impulses helped Daniel to develop protective movements that he was unable to use during the quake. Developing new modes of protection reduced the traumatic aftereffects of the remembered earthquake. Moreover, it helped Daniel to feel prepared for the next one – an inevitability in the area where he lived. There is no doubt that when the next quake comes he will be able to move to safety effectively.

Donna

Sixty-year-old Donna was still mourning the death, five years earlier, of her husband of 35 years. It had been a shocking blow. He had a heart attack while a passenger in the car she was driving. She had driven like a maniac in an attempt to get him to an emergency room before he died. Of course we spent a lot of time processing the incident and her grief. She also suffered a persistent right hip problem, which caused chronic pain. The condition had emerged about one year after her husband's death. A series of orthopaedists, chiropractors, and acupuncturists had helped a little, but the pain persisted. She decided she wanted to see if I could help with that, too. I had her focus on the hip, describing the sensations and being as specific as she could about the pain – its type, location, if it was steady or throbbing, etc. Inspired by Levine's SIBAM model, I investigated other aspects of her consciousness. While she stayed focused on the hip pain, I asked about other sensations in her body. It seemed that the more she focused on the pain, the faster her heart beat. I also asked her to notice what emotions she was feeling. She was scared. I had her stay with those sensations for a few minutes: pain, heart rate, fear. As she persisted her right foot dug deeper and deeper into my carpet. It wasn't long before she took a huge breath and began to sob, 'I drove as fast as I could. I floored the accelerator. It was an old car and I just couldn't get it to

go faster!’ It became very clear that a significant part of her hip problem was this memory of bearing down on the accelerator. This work didn’t cure her physical problem completely, as she had been holding that leg tension for four years. But the pain eased and medical treatment became more effective. The session also facilitated her mourning process. She was able to release some of the guilt she had harboured for not making it to the hospital soon enough (Rothschild 2000: 117–118).

Donna had remembered the trip to the hospital, but had never realised that the pressure she put on her leg was the root of her current hip pain. She knew she felt guilty, but hadn’t remembered how hard she had tried to get there as fast as possible. Beginning with body awareness and then bringing in the elements of emotion and movement helped to clear her memory of the events and forgive herself for not being able to save her husband’s life.

Muscle toning

Another very useful application of non-touch body work with trauma is increasing muscle tone in the client’s body. This might seem a contradiction, especially to the body psychotherapist. It is more common to increase relaxation in our clients. However, there are some individuals who actually become more anxious with relaxation exercises, yoga, etc. (Heide and Borkovec 1983; Lehrer and Woolfolk 1993). With such clients – usually individuals with high levels of PTS or PTSD – muscle tensing will actually work to create more calm than relaxation. Weight training, walking, stairmaster, pushups, situps and so on can all be useful tools for increasing muscle tone and thereby calming for those suffering the effects of trauma. The best way to know if a muscle toning exercise is useful for your client is to ask: ‘Does this make you feel more calm, more present, more clear headed, etc.? Does this make you feel nauseous, spacy, anxious?’ The answer to those questions should help you and your client to decide if a particular toning exercise is useful or should be discarded.

A sample session transcript

K is a single man in his mid-thirties. He has been T’s client for two months. This session is the first of several addressing this particular incident. Two major interventions are illustrated: 1) a body-oriented model for setting up the therapy situation, 2) the beginning use of non-touch techniques to integrate a major aspect of the trauma being addressed – in this case, isolation.

T: How are we sitting – this distance and positioning?

K: It’s fine.

T: What’s happening in your body?

Using body awareness as a guide to setting up the therapeutic space. This is also a good way to begin training body awareness.

K: A little excitement.

T: What are the body sensations?

K: My heart's beating faster and I'm shaking a little.

T: I suggest you experiment with the distance between us.

K moves his chair back from T about 25cm.

T: What happens to your heartbeat and shaking when you move your chair back?

K: Better now. Both are less.

T: What does that tell you?

Making sense of the change in sensations: mind/body integration.

K: I was sitting too close to you. I'm more comfortable now.

T: OK. Tell me just the title of what you want to work on.

This is a strategy for pacing entry into work with the trauma. We go in a step at a time instead of jumping in with both feet.

K: 'A close call – too close!'

T: What happens in your body when you say that?

K: It becomes more tense.

Just naming the title has already been activating. This is not uncommon and helps to alert both client and therapist to the importance of pacing.

T: All over, or somewhere particular?

K: Especially in my chest. It is hard to breathe.

T: Is there anywhere that doesn't feel tense?

K: I feel weak in my legs.

Trauma often gives a feeling of being 'weak in the knees'.

T: Try pressing your feet into the floor so that your thighs tense up. Can you do that?

K: Yes.

T: What happens in your chest when you tense up in your thighs?

K: My chest relaxes a little and I can breathe easier.

This is an example of using muscle tensing to mediate negative reactions. Bringing more strength to the legs made it possible for the overly-tense chest to relax a little.

T: Would you like to talk about what happened? Just the outline, first – the headings.

Again, pacing the telling of his story so that he can digest the pieces.

K: Three years ago I was shot at by a sniper. I was driving in my car, he was on an overpass. I wasn't hurt, he just shot out my rear windshield. I called the police, but as no one had seen the sniper and he left no evidence, they couldn't do anything.

T: What's happening in your body?

K: Only a little tension.

It appears to be OK to go on.

T: OK. What were the next steps?

K: I stopped going out so much.

K cries deeply. A central issue has emerged.

T: I see you are crying. Can you tell me what's happening; what you are feeling while you are crying?

I want my client to be able to think and feel at the same time – the goal of mind/body integration.

K: All mixed up.

T: What feelings are mixed up?

K: Being by myself. No one could help me. No one knew who it was. I didn't know if it could happen again.

T: And so you are feeling?

K: Like lost, completely lost.

T: What are the sensations in your body?

K: Like I am covered with a film.

T: How do you experience that?

K: I feel a bit numb. And you are a little blurry.

Slight dissociation.

T: Have you ever told anyone about what happened?

K: My wife, but it scared her so much I never mentioned it again. And the police, but they couldn't do anything, so I gave up.

T: It sounds as though you were quite isolated during that time.

K: *Eyes watering.* I didn't know who to talk to. The police couldn't help me. I didn't want to scare my wife more. Because she got so scared, I was afraid to tell – and scare – anyone else. I didn't want to make a big deal out of nothing.

T: What were your feelings then?

K: I felt really scared.

K begins to cry.

T: Say that again.

K: I was really scared.

K cries more deeply. The sobs subside after a while.

T: How are the feelings of being scared then, and being scared now different?

K: *Takes a deep breath.* Right now I can relax. Then I was just always wound up.

T: Can you feel that difference in your body now?

K: Yes. I can breathe!

T: You never told anyone how scared you were?

K: No, not really.

T: Can you tell me?

K: I was really scared.

K trembles a little.

- T: I see you are trembling. See if it can be OK to just let that happen.
K continues to tremble for about 30 seconds.
- T: How do you feel?
- K: I feel more relaxed in my chest.
Something changes in K's eyes.
- T: What is happening to your vision?
- K: I can see you more clearly.
- T: And the numbness?
- K: A little less.
- T: What do you think that means?
- K: That I am a little less scared.
- T: Can you say more about that?
- K: After shaking and crying I can see you more clearly. I am relieved to have finally told someone.
- T: Do you think you could tell someone else?
It is important to help make a bridge out to K's daily life, to decrease his sense of isolation there.
- K: That isn't easy for me.
- T: Do you know why?
- K: I'm sort of embarrassed to still be scared about something that happened three years ago.
- T: Is there anyone who might understand that?
- K: Probably my brother.
- T: How do you think he would respond to hearing your story?
- K: I think he would be empathetic. But he might also be irritated I never told him before.
- T: Do you think you could handle that?
- K: Yes.
- T: How might it feel to tell him?
- K: It might be a relief.
- T: Can you imagine telling him?
- K: Yes. I'm doing that.
- T: What happens when you tell him? *K exhales deeply*: Can you feel how much you are exhaling?
- K: It's reducing the pressure inside. I was so confused. I didn't want to scare anyone. I was so alone. *K cries again*. Someone should have seen how scared I was.
- T: How do you feel when you say that?
- K: I feel angry. I was protecting everyone when I was needing support.
- T: What do you think about that now?
- K: I think it's about time I told someone.
- T: When?
- K: I'll call my brother tonight.
- T: How are you feeling in your body?

K: Lighter. Relaxed. Relieved.

In subsequent sessions K was helped to talk with his wife and repair the rift that occurred at that time. Eventually he was able to address his somatic response to having been shot at, releasing that anxiety from his mind and body.

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