Chapter 4.

Transforming Childhood Physical and Verbal Abuse: Mind-Body Approaches to Trauma Treatment

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Erma, a divorced woman in her mid-50s, sat on my sofa, one knee over the other, both feet shaking. Her arms were rigidly crossed over her breasts. In a taut, low voice she told me about being hit repeatedly by her father as a child, and the time he yelled at her and pushed her down the basement stairs, sending her to the hospital with a broken leg. These memories had recently surfaced, and now she found it nearly impossible to force herself to walk past the closed basement door in her own home, safe though she was from the man who was long dead. She kept remembering the experience, and part of her was convinced that someone would suddenly appear at the door and push her down the stairs, even though another part of her knew that her security system would sound the alarm if a stranger tried to enter her house. She was at a loss as to how to handle the extreme fear that gripped her when she attempted to walk down the hall, past the basement door. She could feel herself freeze and numb out even as she spoke to me about the feelings. Could I help?

The precipitating event apparently had occurred two months previously when she fell while walking the dog and landed with her leg under her in a similar position as when she had fallen during the original trauma. No physical harm was done during the recent fall, but over the course of several weeks, the memories of the assault by her father had surfaced, and she felt overwhelmed by her intense anger and fear. Most of the time these

feelings were under control, except when she had to walk down her hallway from the living room into her bedroom, which was several times daily.

She had come to consult with me because instead of fading away, these feelings were becoming more intense. Her anger was becoming so extreme that she was having difficulty relating to her long-time boyfriend, or even her female friends. As she put it, "I am afraid of what I might do if I let myself get angry. I might become an abuser just like my father. I am very afraid of my anger." Consequently, she had isolated herself from her support system. She was finding it difficult to sleep, and awakened several times each night with nightmares about the assault. She experienced difficulty concentrating at work, and startled easily. She was so hypervigilant that she found it difficult to go anywhere other than her living room. She camped out in her living room most of the time, and made her way swiftly to her bedroom only to sleep. She lived alone, so no one had observed what she described as her "bizarre" behavior.

The most distressing part of the entire situation for Erma was the hyperarousal she experienced much of the time. She reported ongoing shortness of breath, hypervigilance, tight muscles, and difficulty concentrating. As she described it, "I feel like I am about to jump out of my skin." She couldn't eat, couldn't sleep, couldn't stop thinking obsessively about the memories, cried for several hours each day, and was "ready to snap anyone's head off if they ask me about it."

Understanding Adult Memories of Childhood Trauma

Being yelled at (verbally abused) and pushed down a flight of stairs (physically abused) by a person of trust is surely a trauma with both physical and psychological impact. In Erma's

case, the trauma had occurred more than forty years previously, but she was feeling its physical and psychological effects anew since the details of the memory surfaced unexpectedly. Not only was Erma experiencing psychological distress manifested through extreme fear and anger, but she also began to have pain in her leg where it had been broken when she was a child. Over the years, her body stored the memory of her childhood trauma (Rothschild 2000).

To understand how traumas of childhood physical and verbal abuse become events that affect emotional functioning across the life span, we need to understand three interrelated responses: (1) the physiological response to a traumatic event; (2) the submerging of the experience into a place in the person's memory where it is not available to conscious thought but still exerts influence on a day-to-day basis; and (3) the retriggering of memories of the original event with physiological responses similar to those at the time of the original event. The following discussion offers further understanding of Erma's response to the retriggering of memories of her childhood trauma and the re-experiencing of physical and emotional sensations equal to the trauma of that childhood event.

As stated in the preface, recent advances in brain research identify structural changes in the brain following trauma (Hipskind and Henderson 2002). Such a response is not surprising given the cascade of events that occur in the brain when we are faced with a life-threatening traumatic event. Such a threat activates the brain's limbic system (specifically, the amygdale and the hippocampus, thought of as the more primitive, preverbal parts of the brain) and the sympathetic nervous system and releases hormones that prepare the body for fight or flight. The physical manifestations of this response involve tensing muscles, heightening peripheral vision, reducing digestive enzymes, and a host of other physiological responses that increase the chances of survival by enabling the person to move rapidly either to fight or flee. Hormones released by

the adrenal glands, such as epinephrine, norepinephrine, and cortisol, help the organism mobilize the energy required to deal with the threat, in ways that range from increased respiration and heart rate to enhanced immune function. Normally, the organism will be prepared for fight or flight, but a third response is possible: freezing. Freezing also has survival value, such as when a cat stops playing with a bird that no longer moves. The freeze response has the effect of numbing the organism so that it feels less pain when death is inevitable. Clearly, though, freezing has less survival potential than either fight or flight.

Once the traumatic incident is over and/or the fight or flight response has been successful, the release of cortisol will halt the alarm reaction and the production of other stress hormones, bringing the organism back to homeostasis. For those with posttraumatic stress disorder (PTSD), the adrenal glands do not release enough cortisol to halt the alarm reactions. Thus a continuing alarm reaction occurs, manifesting as hyperarousal – the state of high anxiety and physiological tension shown in feelings and actions such as hypervigilance, exaggerated startle response, and difficulty concentrating (Yehuda et al. 1990). Physical reserves are accessed to escape a predator or fight an assailant, but they are not meant to be a long-term response. All of these reactions are instantaneous, instinctual responses to perceived threats and are not under our conscious control. We cannot override them to make informed, logical decisions at the moment, and we cannot convince our limbic system not to react the way it these early, primitive survival reactions dictate.

The limbic system is also involved in remembered trauma. The amygdala aids in the processing of highly charged memories, whereas the hippocampus puts our memories into perspective with regard to time and space. During a traumatic threat, however, the activity of the hippocampus often becomes suppressed, so it is not able to process and store an event (Nadel

and Jacobs 1998; van der Kolk 1994). Thus stored traumatic memories are not specific to the time and space in which they first occurred, and they can continue to invade the person's present life.

The autonomic nervous system works to counterbalance the sympathetic nervous system by calming the organism, slowing the heartbeat, relaxing muscles, increasing digestion, and stopping the stress response. If PTSD is to be relieved, hyperarousal must be moderated before it wears the person down to numbness.

Traumatic events leave distinctive footprints on the brain. Those who suffer from acute and chronic PTSD experience exaggerated sensitivity and heightened reactivity in the parts of the brain that process emotions, sensations, and images. Consequently, trauma survivors are more responsive to sensations, emotions, and perceptual cues than those who have not been exposed to trauma (Naparstek 2004). On the other hand, the part of the thinking brain that translates personal experience into language, Broca's area, becomes temporarily less active after a traumatic event. Thus, trauma survivors are acutely aware of danger signals in the form of nonverbal cues in their environments, but they are not able to talk about these cues and process them as they would normal cues. Instead, they react – quickly and extremely – to anything their limbic systems perceive as a threat, including memories and perceptions. Only when a person is sufficiently calm can he or she focus on ideas and words.

Responses to Adult Memory Trauma Using Mind-Body Approaches

Trauma has been recognized as a multi-faceted problem that disrupts functioning on a systemic level involving both the body and the mind (Damasio 1994; van der Kolk 1994). "Mind-body medicine" has been defined as "an approach that sees the mind – our thoughts and

emotions – as having a central impact on the body's health" (Goleman and Gurin 1993:5). In Erma's case, the use of mind-body techniques helped to calm her physical and emotional arousal as she struggled to heal from the aftereffects of the trauma of remembering the abuse she had suffered as a child.

Treatment strategies that are considered to be in the mind-body realm include relaxation techniques, guided imagery, biofeedback, and meditation (Finger and Arnold 2002). These techniques, discussed in more detail below, are primarily used for stress reduction. In addition, social support, prayer, hypnosis, healing/therapeutic touch, exercise, journaling, energy therapies, and expressive arts may also be employed to integrate the mind (including emotions and spirituality) with the body (Davis, Eshelman, and McKay 2000; Phillips 2000).

I had worked with Erma for several months on two occasions during the past two years for both physical and emotional problems. She lived with several chronic ailments, including dermatitis and inflammatory bowel syndrome. In addition, she experienced very volatile emotional reactions to what for other people would be small events. Our previous sessions had involved her learning to adjust to these difficult circumstances, developing and using her support system, learning to take less responsibility for how situations turned out, and integrating relaxation techniques into her daily life. Our relationship was strong. I had suspected that some form of trauma had been part of her life, but until now she had had no concrete memories of anything other than a loving childhood.

Regular talking interventions are unlikely to be effective when the trauma survivor is in a state of hyperarousal. The person literally cannot focus her attention on what others are saying. When a trauma survivor is in this state, it is important to provide safety (Herman 1992), which helps decrease the arousal level. In the past, Erma had responded very well to guided imagery

and relaxation/breathing. These techniques enabled her to feel more in control and helped her to calm herself. It seemed to me that the same techniques, along with others more specific to dealing with trauma, might be useful again,

My diagnosis at the time of this most recent contact was that Erma was suffering from acute posttraumatic stress disorder. Until recently, the memories of falling down the stairs and the angry look on her father's face when he yelled at her and then pushed her had not been accessible to her. She had remembered that at some time in her childhood she had broken her leg, but the details were foggy, as were many memories of her childhood.

Stages of Trauma Treatment

Judith Herman (1992) has identified three stages for trauma treatment as establishment of safety, remembrance and mourning, and reconnection with ordinary life. My model for trauma treatment also contains three intertwining stages, ones that echo some parts of Herman's stages yet also integrate more fully the awareness of mind-body connections. Each stage will now be briefly defined, then discussed in greater detail, including application to the work with Erma.

In Stage 1, shortly after the traumatic event, the person may be held hostage to hyperarousal and other reactions to trauma, including dissociation, flashbacks, or emotional numbing. The person is helped to feel safe and to calm the hyperarousal by learning techniques for self-soothing. In Stage 2, the survivor continues to use calming and soothing techniques while delving deeper into the trauma and using body-based treatment techniques. Stage 3 involves recognizing how trauma changes a person, making meaning of the experience, and integrating the changed self into a new way of being, often in a different, more authentic direction. The survivor may emerge stronger and more resilient than before the trauma.

Stage 1: Calming Arousal Level

This stage is discussed as calming arousal level although it also deals with other symptoms. Techniques used at this point are also helpful in calming a generalized stress response. When arousal level is extremely high, there is no point in trying to emotionally process the trauma. The emotions associated with the traumatic experience are triggered by the slightest stress, and it feels as if there is no safety anywhere. In this stage survivors learn that they can control a high arousal level, flashbacks, intrusive memories, dissociation, or whatever symptom is most alarming at the time.

Slow and steady breathing is a first step in calming arousal level. Part of the stress response is to hold the breath or to breathe shallowly. Many different breathing techniques have been described in the professional literature, but all involve an emphasis on breathing deeply and slowly from the diaphragm (Hendricks 1995; Lewis 2004). Teaching survivors to notice and change their breathing patterns in this way is the first step in helping them to calm themselves. Audio CDs are useful when an individual is first learning this technique (e.g. Byington 2004; Weil 1999).

Second is the safe place meditation. Many survivors have no memory of ever having felt entirely safe in their lives, so this exercise may introduce the physical awareness of safety. The survivor imagines a place where she feels absolutely safe, and she focuses on experiencing sensory perceptions as she imagines herself there. For example, if the safe place is a beach, the person can be instructed to hear the waves, feel the ocean breeze, taste the salty air, feel the sand beneath her feet, and watch seagulls overhead. This technique for calming is widely used for teaching people to calm and self-soothe.

Experiencing a dual awareness of past and present is a third technique that is useful for calming arousal levels and stress responses. This exercise gently reminds the person that, as vivid as the flashback experience is, it is not happening now. Slowly the person's awareness returns to the present moment, with physical sensations providing the grounding for separating past from present experience. Even when a survivor is re-experiencing the trauma, he can be taught to feel his back against a chair, his feet on the ground, his breath moving in and out.

The fourth technique for calming is the use of relaxation exercises. By definition, a person cannot be tense and relaxed at the same time. Because it may be difficult to access the exercises when arousal level is high, it is helpful to practice them at times other than when they are needed to calm arousal level, so that when needed they can be more readily available. Muscle relaxation helps to move a person out of hyperarousal. Relaxation exercises include progressive relaxation, release-only relaxation, and autogenics (Davis et al. 2000). Progressive relaxation involves tightening muscles before relaxing them, and release-only relaxation involves focusing on various parts of the body in order to consciously relax them. Autogenics relaxes the body by imagining that it is, for example, warm and heavy.

These Stage 1 techniques for lowering arousal level work to calm and regulate over-taxed emotional responses. They are most effective when they are practiced regularly, during times of relative calm, so that when arousal level is highest, they are immediately at hand. In addition, after the person has learned these techniques she can access them directly, without the presence of a therapist or coach; thus the survivor is empowered to be more in control of her reactions. Since trauma wreaks havoc with one's sense of control, reestablishing it in some form is crucial for recovery.

Erma and I worked together for approximately six months. For Stage 1, I helped her to identify a safe place in her home and to remember what it was like to feel safe. We used a form of systematic desensitization (Wolpe 1958) to help her stay relaxed while repeatedly imagining that she was walking past the basement door. We worked with her breathing and with a dual awareness to help her control her arousal level. When she felt thoroughly relaxed through the use of relaxation techniques, she walked past the basement door and was able to stay relaxed.

Stage 2: Healing and Integration

Recovery cannot be said to be complete until the trauma no longer feels like a fresh wound but instead resembles a scar – not forgotten, but no longer a constant source of pain. All treatment methods involve moving into and through the trauma. Not all treatment methods require that the trauma be remembered in detail, but many do.

Once arousal has been moderated and the person can identify a sense of safety, it is important to process the trauma. This task involves moving memories from implicit to explicit memory storage, extinguishing the post-traumatic psychological and physiological reactions, and creating new associations and meaning for the experience. Numerous researchers have suggested that traumatic memories have been dysfunctionally stored in memory, possibly because of inadequate hippocampal functioning (Gunnar and Barr 1998; Shalev, Bonne and Eth 1996; Shapiro 2001; van der Kolk 1996b). Traumatic memories tend to be dissociated and stored initially as sensory fragments that have no linguistic components, or as implicit memory (van der Kolk 1996b). These memories can be thought of as wandering around in the brain without a file for storage. One goal of treatment is to help people weave the sensory fragments together and

create a personal narrative that can be talked about and then stored appropriately, in explicit memory.

Traumatic memories are triggered by something that is associated with the trauma, whether or not it can be identified. This trigger could be simple or complex, conscious or unconscious. For Erma, the trigger had two parts. The first was her falling and landing in a way that replicated the position of her fall in the original trauma. The second, which most likely happened while she still felt the physical pain in her leg from the fall, was when she walked past the place of the original trauma, the basement door. Just seeing the door triggered physical and sensory memories of the trauma. Individuals who have PTSD are more resistant to extinction of these strong reactions than other people are (Rothbaum and Davis 2003). Therefore, a goal of treatment is to help survivors extinguish reactions to the triggers or to learn to tolerate them without going into a fear reaction.

Finally, a third goal is to help survivors learn different ways of being in the world, especially with respect to how they inhabit their bodies. Trauma tends to dampen somatic experiences, and survivors often have a difficult time identifying physical sensations or emotional states. They tend to ignore or discount intuition, especially as related to safety issues. A person who always feels unsafe will not be able to differentiate times when she is really unsafe from all the other times. Therefore, it is very important that trauma survivors learn to recognize and trust somatic experiences and emotions, as well as their own instincts (Heller 2001; Levine 1997).

A number of excellent mind-body treatments have been developed to help survivors move through this stage of healing, and three of them are described here. Each focuses on one of the goals of this stage more than the others do, so it is important that a therapist or coach who is

trained in trauma treatment help the person navigate through all of the goals. Since no single treatment is appropriate for every trauma survivor, it is important that the therapist and the survivor work together to come to agreement about which treatment will be the best choice for the particular situation. The skill level of the therapist is a crucial factor in this second phase of treatment. Therapists who have not been trained in a particular technique have an ethical responsibility to avoid attempting it; they should, instead, refer survivors to more-experienced therapists if and when the need arises.

One of the most carefully researched and well-known treatment is eye movement desensitization and reprocessing (EMDR), developed in the 1990s by Francine Shapiro (2001). It shares some elements with other forms of therapeutic exposure methods that use cognitive-behavioral techniques to reduce the emotional distress of traumatic memories, and it has been shown to have similar success in reducing the symptoms (Briere and Scott 2006). The essence of this therapy is the use of bilateral stimulation – i.e., stimulating both the left and right hemispheres of the brain -- while the individual directs his or her attention to traumatic images. Imagining and feeling into a safe place is the first part of the treatment. Only when the person feels safe is the bilateral stimulation introduced. Some examples of methods used by practitioners are alternately tapping on the person's right knee, then the left knee, the clinician moving her or his fingers smoothly back and forth as the client's eyes follow from side to side, or alternately playing sounds in each ear. The survivor tells the narrative of the traumatic experience while the practitioner monitors the amount of emotional disturbance, and the bilateral stimulation is continued until the disturbance level has been significantly reduced. As the treatment continues, a new understanding of the trauma is generally gained, along with a lower arousal level and less-vivid images.

The goal of this treatment is to eliminate emotional and somatic distress in a very short time, while producing cognitive insights and shifts in self-perception. EMDR theory holds that these techniques change the way memories are stored and therefore reduce arousal level and help the person to react less strongly to the triggers. EMDR is not appropriate for every client. Generally, it should not be used to treat people who are not soothed by the safe place meditation or who have high levels of dissociation. It should be used with caution with people who have schizophrenia, active drug or alcohol addictions, neurological impairment, epilepsy, or possible suicidal tendencies (Shapiro 2001).

A second form of treatment helps the person focus on internal body awareness and kinesthetic sense, both of which are inhibited by trauma. Increasing body awareness is included in many of the developing approaches to trauma treatment (Pesso and Crandell 1991; van der Kolk 2002) and is strongly supported by the therapists who work with it (Naparstek 2004).One of the most well documented body-based treatments is somatic experiencing (SE), developed by Peter Levine (1997). SE focuses on internal body sensations, the primary method of accessing the effects of trauma. As the person attends to these sensations while being relaxed, physical and emotional feelings surface and can become the focus. This helps the body release from the "freeze" state experienced in the original trauma and return to normal.

A third approach is the use of guided imagery. The efficacy of imagery in the treatment of various conditions is widely supported by research; it has been used to alleviate anxiety and depression (Jacobs 1990; McKinney et al. 1997), to enhance recovery from surgery (Dreher 1998), and to increase immune function (Gruzelier 2002). Although many of the newer body-based therapies use imagery in their protocols, little has as yet been done yet with the use of

imagery in treating trauma to help move the trauma survivor through the trauma memories. Bellaruth Naparstek's work (2004) is one exception.

In this approach, the right brain is activated by the use of symbols to process the trauma. "The imagery for this stage goes deeper and deliberately aims to help the survivor reestablish a relationship with the world of feelings; face down unpleasant symptoms; move under them, to the core of the hurt; and reestablish a connection with a broader, more spiritual perspective, big enough to hold and transform the enormity of the pain and loss" (Naparstek 2004:229). The survivor listens to guided imagery scripts or audio CDs repeatedly. These scripts are carefully devised to bypass the thinking (left) brain and go directly to the world of sensations and visual imagery. Symbols are used to process the trauma so the person does not have to access the trauma directly and risk being retraumatized. For example, one guided imagery script takes the person through an imagined landscape that is filled with "crumpled piles of shattered dreams" (Naparstek 2004:253) and moves her through the hurt to a place that is deeper, her spiritual essence. This imagery is designed to be experienced repeatedly, so that the triggers are gradually desensitized and the person is able to understand that she is greater than just the trauma experience.

In the work with Erma in Stage 2, we explored the assault itself. Although she quickly recovered her comfort level in her home and was able to walk past her basement door without intense fear, the sadness and anger about the incident continued for some time. We used EMDR to help reconstruct the incident and to process the emotions. She talked with her mother and brother about the assault, which had never been attributed to her father but had been passed off as an accident. Her mother was very apologetic for failing to protect her daughter, and mother and daughter talked at last about their mutual fear of this man who had terrorized them both.

Erma explored her body sensations and became more aware of pains in her leg and back. She began to regularly receive massages and to practice yoga.

Stage 3: Making Meaning

Trauma changes a person at all levels: brain functioning is different, emotions may be dulled or brought closer to the surface or both, coping in the world is altered. The trauma survivor must grieve for what she has lost, for the person she was and will never be again, and for the loss of innocence embedded in the trauma experience (Herman 1992). In addition, the survivor must find some larger life meaning from the experience – some way that the person is changed for the better and not just for the worse. Trauma survivors often identify ways in which they are better, stronger, or more compassionate as a result of their experience. Trauma sensitizes the right brain, increasing the person's ability to call on imagination, intuition, and emotional-sensory experiences (Naparstek 2004). I think of this stage as "finding the gift" in healing from the trauma.

As Erma moved into Stage 3, her volatile emotions gradually began to subside and her physical symptoms abated somewhat. All was not perfect in her life, however. She remained easily rattled by relatively minor life events and tended to feel badly about herself when someone treated her poorly. Dermatitis and bowel problems continued, but at a decreased level. Her emotions were more volatile than she wanted them to be, even though she was able to work and love successfully. She continued to have trouble with affect-balancing, especially when she neglected her calming strategies of regular exercise, journaling, and listening to relaxing audiotapes.

Increasingly, though, she reconnected with friends and strengthened her relationship with her partner. She felt more worthy of giving and receiving love. She understood how her father's violence related to her being averse to risk and less assertive in many areas of her life. She was unwilling to forgive her father for how he had hurt her, but she was grateful that she had survived this man's abuse. She was also grateful that she had not continued the cycle of abuse in her life and that her grown sons were gentle and loving men. She wanted to help other survivors of abuse. She wrote her story in the hope that it would help someone else. After six months, she left therapy and was able to cope reasonably well on her own and with a newfound feeling of purpose.

Vicarious Trauma

It is well known in the trauma treatment field that vicarious trauma is a danger for therapists. It is very easy to be affected by the intense emotions of trauma survivors, and the ability to empathize makes this tendency even more problematic. Many practitioners have experienced trauma themselves, and unless the trauma has been resolved, repeatedly listening to other people's trauma can retraumatize them. It is especially difficult to avoid retraumatization when working with clients who have experienced the same sort of trauma as one's own.

Mind-body techniques are very useful for therapists as well as for clients. For example, being aware of emotional and physical responses to what clients tell us is crucial. When we realize we are holding our breath, we may be mimicking what our client is doing. Breathing consciously is therefore helpful for both of us. We need to be aware of how working with a particular client is affecting us physically. In order to be effective, we need to be able to experience a "dual awareness": of both the client's subjective state and our own.

When Erma described her fear of walking past the basement door, I could feel my jaw tightening and my breath becoming shallow. Thought her fear was not a major fear of mine, I could empathize, and I needed to unclench my jaw and deepen my breathing in order to separate my experience from hers.

I find that it is helpful to take a few minutes between clients to move around, air out the room, and remember my own physical and emotional experience. I have also found it helpful to meditate regularly, exercise, and use other mind-body techniques to rid myself of fearful emotions that are not mine. Support systems are very important for therapists as well as clients. Mind-body techniques are far more useful for clients if the therapist is familiar with them and can speak from experience. Just as these methods help clients to heal from trauma, they can help people who work with trauma survivors to sustain their ability to help.

Reflections on the Empowerment Principles

Mind-body approaches for trauma treatment are consistent with the principles of empowerment practice. As relaxation skills are strengthened, for example, the oppressive force of post-trauma-related tensions and anxieties is diminished. These approaches require client and practitioner to work together to reach the goal of cognitive shifts, work that can be done only through mutual cooperation as the practitioner assists the client from a position of equality and from an acute awareness of the client's specific needs. These approaches can be highly effective in changing the survivor's perspectives. The changes, in turn, can have a positive impact on the person's relationships with others. The practitioner's ability to integrate and build the support of those others into the client's response to the trauma helps to maintain the strengthening results gained from the use of the mind-body approaches in the treatment. To consider the application of

these principles in a more specific sense, each will be discussed in the context of the work with Erma.

Building on Strengths while Diminishing Oppressive Factors

The oppressive force of Erma's memories of her father's abuse was clearly interfering with her ability to function on a day-to-day basis. Her inability to eat, to sleep, and to stop obsessive thoughts of the memories sparked an array of chemical responses in her body. Therefore, her own body took on the role of a type of oppressor, so that Erma in a sense was living with an oppressor within. As mentioned earlier, she was literally taken hostage by these memories and reactions. It became crucial for her to call upon her own strengths and the calming resources within herself to counteract the oppressive force of the memories.

She gained strength through her ability to control her breathing and through her use of dual awareness, both of which contributed to a decrease in her arousal levels. Controlled breathing helped her to stay in the present moment and to recognize the safety of the present in contrast to the threat of the past memories. The use of the mind-body techniques also helped desensitize her to concrete memory triggers so that she could walk past her basement door, for example, without losing a sense of relaxation.

Working from an Awareness of Specific Need

Erma's specific need was directly related to a felt sense in her body, freezing and numbing out, in response to extreme fear (emotional response) that grew out of the intensity of her memories as experienced in her thinking mind. The body-mind relationship was immediately evident in her presentation of her difficulty. Mind-body forms of treatment – i.e., breathing and

relaxation – have a direct relationship to the emotions and thought processes, and they are especially effective with promoting change when directed to the client's specific need.

No single treatment is appropriate for every trauma survivor. Erma and I went through a step-by-step process to determine the treatment choices that would best fit her need. That process included describing options and allowing her to choose the ones that appealed to her. We had the advantage of having worked together before, so we were able to reintroduce the Stage 1 interventions that had been effective in the past. Erma was interested in using EMDR, and that was very helpful for her.

When clients are nervous about EMDR, however, we move to something else. It is very important that clients' intuition about what might be helpful for them be invited and respected. For example, the most important intervention for one client with very early trauma was for her to purchase a baby doll and spend time daily rocking and singing to it. That activity seemed to allow her to give the doll some of the nurturing she had never received herself, and she was able indirectly to soothe the very raw and traumatized places within herself. Finding the person's best treatment choices involves intuition, inspiration, and sometimes trial and error by both client and therapist.

Assisting Clients as they Empower Themselves

Trauma disorients and shocks people, throwing them out of their normal routine. In doing so, it can destroy all sense of trust in self and in one's ability to cope. Many trauma survivors require some assistance from others to regain a sense of going forward with their lives without the fears and memories continuing to overwhelm their daily activities.

Erma's ability to learn how to self-soothe through relaxation techniques was an immediate skill that empowered her in the session and one that she could take with her and use at home. Two central directions for empowerment practice are: (1) providing information to clients through an educational or learning experience and (2) helping to enhance coping skills (Lee 2001; Wise 2005). Both were used to assist Erma while she learned and practiced the techniques and went on to use them on her own apart from our sessions.

Integrating Support from Others

An important step in Erma's recovery came when she was able to talk with her mother and brother about her father's assault. Erma became aware that she was not alone in her experience of feeling terrorized by this man. She further learned that it was the numbing and silencing effect of the terror itself that had kept her mother and her from sharing their experiences with each other. Erma was very touched to know that her mother loved her and wished to hear about Erma's experience. Telling each other about their struggles brought them closer than they had been in years.

Also, as Erma moved into Stage 3 of her work, she reconnected with friends again for the first time in months and also reached out to strengthen her relationship with her partner. These reconnections served to strengthen how she felt about herself in ways that contradicted her earlier needs to isolate herself and feel overwhelmed by her fears.

Equalizing Power Differentials and Using Cooperative Roles

Trauma and, as in Erma's case, the retriggering of earlier trauma raise a sense of powerlessness in such a way that the person's sense of strength and personal power is displaced.

Even while Erma reached out for help from a place of strength, she also came to our first session aware of how powerless she felt in light of her recent memories of the abuse by her father. From this position and from our culture's historical perception of a power hierarchy in helping relationships, it was not unexpected that Erma might perceive the therapist as having greater power than she did to influence the outcome of the healing process. Even though our roles are defined differently by nature of the purpose of our work together, the strengths we bring as individuals are viewed from a vantage point of equal personal power. Both people's strengths are necessary in equal measure for a helpful and healing outcome.

I communicated this stance to Erma by listening carefully to her story, by involving her in all decisions about which interventions would be helpful, and by respecting her choices and her pacing in moving through the various stages of responding to her traumatizing memories. No action in these approaches proceeded without Erma's agreement to participate and the assurance that she could stop the procedure at any time.

Conclusion and Recommendations

Trauma survivors are never the same people they were before the trauma. Healing is possible, however, and many survivors are able to put the experience behind them and live in the present moment. Some are able to take the next step, to transform themselves into stronger, more sensitive, more resilient people than they were before the trauma experience. Transforming trauma is empowering for those who are just entering the healing process, as well as for those who have taken on the task of helping to heal trauma. Trauma survivors may always be more susceptible to stress reactions and more quick to arousal than they might have been if there had been no trauma (van der Kolk 1996a). Survivors who fare best are those who take charge of their

own healing process, who use several different approaches to healing, and who work on themselves on many fronts, either simultaneously or in sequence (Naparstek 2004).

As people gain a more calm perspective about the trauma, they are able to move out of isolation and struggles in relating to others; they become able to rejoin the world. They learn how to respond to questions about the trauma and how to maintain the self-care that is emphasized in treatment. They learn to maintain the gains they made and to redirect their attention away from the trauma and its treatment and toward the next stage in life. This is the final part of the healing process. If it has not occurred before, the person moves from a self-identity as a trauma victim to a trauma survivor.

From my experience of working with many trauma survivors, I believe that healing from trauma nudges people to move in a different direction in their lives, a direction that better suits them after the trauma, even if it did not seem as desirable before the trauma. Part of finding the gift in the healing is finding a meaning that is larger than the trauma itself, even a spiritual perspective about the event. It encompasses the new narrative about the trauma. As people tell the story of their trauma experience, without triggering the previously experienced negative responses, they are able to move beyond it and perceive themselves as no longer limited by the experience. Usually people move more slowly in the world than they did before the trauma. It is not uncommon for them to want to help others who have suffered similar traumas. Trauma survivors often find that their priorities change as they become sensitized to what is really important to them.

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