Towards an Integrative Model of Trauma Therapy
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This chapter describes an integrative model for trauma work, using a case study to illustrate the stages of the unfolding therapeutic process. Each stage is followed by a discussion which explores my thinking and the different therapeutic approaches and techniques I have used. My focus is on the potential - and the difficulties - of integrating the diverse and often contradictory approaches within an overall holistic and relational framework.

The term 'trauma' is often used loosely to describe a wide range of disturbing individual or collective experiences. In contrast to frustration, pain, anger and disappointment which constitute an integral part of human life, this chapter focuses on trauma as a life-threatening experience, with a specific impact on the bodymind system, diagnosable as Post-Traumatic Stress Disorder.

Background to case illustration:

D. was referred to the Traumatic Stress Service at the Maudsley Hospital following a suicide attempt. A 59 year old man, his life had taken a dramatic turn two years earlier. When trying to stop a group of young thugs from assaulting someone, D. was badly beaten up. He was treated for multiple injuries, but beyond the necessary medical procedures and investigations was expected to recover fully within a short time. Nothing had prepared D. for what was to follow: he was unable to go back to work, or even leave his house alone. He was constantly haunted by memories of the assault, unable to sleep and plagued by fear and frequent panic attacks. Everything reminded him of the assault and he found no means of escaping from intrusive flashbacks. He could not understand his feelings and was ashamed about being out of control.

An introverted, shy, working-class man, D. belonged to a generation that believed "if you do not think about it, it will go away." He spoke to nobody about the inner hell consuming him. But, despite his wife's admonition to "just forget about it and move on", his insomnia, depression and panic continued to build until eventually D. attempted suicide.

At the Traumatic Stress Service D. was diagnosed with Post-Traumatic Stress Disorder following a single traumatic event, and offered 12 sessions with an option to continue for another 12 following a review. This was different from the open-ended contract I was used to, and I therefore approached our first session with a mixture of excitement, anxiety and curiosity.

A person suffering from PTSD is chronically 'stuck' in the experience of the traumatic event and - to various degrees and on various levels - re-lives it over and over again, as if it were happening in the present moment. The activated 'fight-flight' response continues to release the same chemicals and neurotransmitters as if trapped in an ongoing life-threatening situation. They often experience 'flashbacks' which "involve highly disturbing replays of implicit sensory memories of traumatic events, sometimes with explicit recall, sometimes without" (Rothschild 2000:45). They may also develop avoidance behaviour, trying to anticipate and avoid any trigger that could re-activate the trauma.

As trauma is essentially experienced in the body, PTSD symptoms also manifest through somatic disturbances and dissociation (Herman 1992: 42, de Zulueta 2002: 53, Levine 1997: 136).

PTSD significantly alters brain function. Research shows that not only during the traumatic event itself, but also during any acute re-experiencing of it, it is mainly the brain stem and the limbic system which are activated. The left hemisphere of the cortex is shut down (van der Kolk 1996: 293). Functions such as the ability to talk, to process information on a cognitive level, to differentiate between past and present, to make sense and find meaning - are unavailable during any re-experiencing of the trauma and chronically impaired even between episodes of re-traumatisation. People who are locked in a traumatised state find it exceedingly difficult to talk, understand or make sense of what has happened, and do not benefit from trying to do so. They need to be met on a different level, corresponding to those levels of their brain that are functioning.

The limbic system regulates the Autonomic Nervous System (ANS) which has two branches: the Sympathetic Nervous System (SNS) and the Para-Sympathetic Nervous System (PrNS). When the limbic system activates first the sympathetic branch of the ANS to meet the danger, and later the parasympathetic to recover from it, these are normal, healthy responses. What turns these responses into PTSD is the chronic simultaneous arousal of the two branches, long after the threat has passed and been survived.

There are different types of trauma:
1. Single event trauma: an incident that occurs once, usually in adult life, typically involving unexpected, sudden shock.
2. Developmental trauma: occurs in childhood and usually carries elements of neglect or abuse. This has a deeper impact on the psychological and physiological structure as it affects the developing child's perception of self and other and strongly impairs the capacity for self-regulation. This type of prolonged traumatic experience can lead to the development of complex PTSD (Herman 1992) or Disorder of Extreme Stress (van der Kolk et. al. 1996c).

In my practice, I have often encountered clients who sought treatment for a single-event trauma, whilst reporting some symptoms of complex PTSD. They have managed to dissociate memories and feelings of early trauma, to function with some degree of success by numbing, self-medicating, etc. (van der Kolk 1996: 282). They have accepted the neurotic equilibrium governing their lives as given, until a recent traumatic event disturbed this shaky foundation. During the process of working with the body and unpacking layers of defences, the connection between the developmental trauma and the recent event can be made.

The human capacity to recover from a single traumatic event is partly influenced by the robustness of a person's emotional resources. People who have experienced a disorganised or insecure attachment (Ogden, Minton, Pain 2006: 48-58) and were not able to internalize a "good-enough" object, lack the sense of safety and confidence in themselves and the world, and are therefore unable to build a solid foundation of emotional and indeed physiological internal resources. At the root of *any* level of PTSD, then, lies some degree of developmental trauma.

First steps: creating the 'container'

> *D. arrived for our first session meticulously dressed in a suit and shook my hand nervously. He told me he finds it hard to talk about what happened, and although he desperately wants to get better, he does not want to remember or talk about "that dreadful night". He proceeded to tell me about his avoidance tactics: not leaving the house, not talking to people, not watching TV and minimising contact with any stimulus that might trigger a memory or a flashback. This indicated that his trauma was not integrated into a narrative which he could assimilate, contain and share; and that any attempt to demand that he share it could result in re-traumatisation.*

My first intention was to establish a working alliance. I gave D. some general information about trauma, PTSD and the typical symptoms of this condition. I explained the physiological mechanisms linked to his flashbacks and panic attacks and acknowledged the psychological purpose of avoidance behaviour as a means of controlling his terror and rage and preserving his sanity.

After using this kind of 'psycho-education' to acknowledge, normalise and make sense of his feelings, we discussed his wish to heal and connect with life again. I suggested a treatment plan which D. expressed enthusiasm to embark on, whilst voicing his anxieties and concerns. At this point, it felt as though we were working as a team, thinking together and sharing our experiences.

In the sessions that followed we worked mostly towards establishing D.'s safe place and looking at his resource. During this time, we hardly talked about the assault and did not specifically focus on PTSD symptoms, staying instead with the first key steps in trauma work - building a safe foundation, and learning the language of the body by tracking the sensations and impulses arising in it (Ogden, Minton, Pain 2006).

I invited D. to tell me about his family and background. His father was a rigid authoritarian man, a sergeant in the military police, then a prison warden, who also had a successful career as a boxing champion. His mother was a soft, gentle woman, bullied by an aggressive husband who often beat her up. She was unable to protect D. from his father's violence and he was also regularly bullied and beaten. Throughout his childhood D. felt he had to protect his mother, and it was he who, at the age of 8, called the police to rescue his mother from one particularly violent attack. From that day on, the father was explicitly sadistic and cruel towards D., humiliating and assaulting him verbally and physically. D. tried to run away from home a few times but had nowhere to go and felt obliged to return and protect his mother. Prior to this therapy, D. had never talked about his childhood with anybody. Feelings of shame and humiliation - so common in childhood abuse survivors - dominated his perceptions and made him feel guilty and contaminated. He had never made any connection between the first years of his life and the recent assault.

The un-packing of the traumatic event is a painful and demanding process. The client's bodymind system is geared towards avoidance, numbing and suppression of the unbearable memories. These avoidance tactics function with the force of a survival instinct that guides the client toward protecting himself from whatever – in his perception – poses a danger to his psychological integrity. Yet, there is also an impulse in the system towards a true healing that can occur only when the suppressed and denied parts of the experience can be integrated and processed. This conflict, as well as the potentially explosive traumatic material itself, requires a solid, safe and sensitively attuned 'container'.

In working with trauma, the containing function of the therapeutic relationship acquires extra significance, as the trauma has usually been experienced in isolation. Even if other people were involved, as perpetrators, passive witnesses or fellow victims, the subjective reality of the victim is that no-one was there, leaving him to face possible death on his own. Feelings of shame, humiliation and helplessness contribute to this prevailing sense of isolation, and the internalised sense of guilt and badness prevents the victim from reaching out and accepting - let alone initiating - any contact. In situations where the victim is threatened into secrecy, the sense of isolation is more extreme and creates a secondary layer of trauma.

Establishing a relationship in which the traumatised person can share his experience is crucial to trauma work. It is often a slow and tentative journey in which the client needs to test again and again the therapist's capacity to contain the horror of the traumatic experience without being destroyed or overwhelmed by it. In order to pass the client's unconscious tests of her and eventually

become the 'containing other', it is crucial that the therapist can demonstrate her capacity to carry both negative and positive transferential feelings. A client who has suffered harm at the hands of others finds it extremely hard to trust that harm is not going to be part of the current relationship and will search the therapist for hidden motivations and investments. He is likely to scan her for non-verbal signals such as tone of voice, directness of eye-contact, body movements etc. Like an animal in danger, the traumatised client relies on such flashes of perception and is hyper-sensitive to the tiniest indication of possible threat or betrayal.

In body psychotherapy this way of perceiving the other through attunement is called 'energetic perception'. The client's experience of the therapist as the safe containing object is measured not by the verbal cognitive exchange between them, but by the client's energetic perception of the therapist's embodied presence and the sense of congruence between the therapist's verbal and energetic messages. This level of relating depends on the therapist's moment-to-moment attunement to her own bodymind responses - to the client, the trauma and the transferential relationship which is constellated in the room. It is only when the therapist can attend to the client and herself as an embodied system that she can provide a container that might feel safe enough for the client.

The next important step is the establishment of a 'safe place': a concrete, observable resource, anchored in the client's life - either now or in the past. It is not an internalised resource like self-confidence. It is a current or remembered site of safety and protection, ideally "an actual, earthly location that the client has known in life" (Rothschild 2000: 95). When imagining himself in this safe place, the somatic resonance via its smells, colours, sensations and feelings needs to be strong enough to generate an embodied experience of its safety in the present moment.

As the client's bodymind system reconnects with such a sense of safety and pleasure, the triggers activating the arousal of the ANS lose their affective charge and balance is restored. Only when the therapist is confident that the ANS is able to tolerate the level of possible re-traumatisation created by the current processing of trauma, can she invite the client to engage further**.** This limited capacity to bear the internal reactions to traumatising triggers and stimuli is also known as 'window of tolerance' (Ogden 2006 p.26). Thus, working with the safe place is one of the most effective tools in helping hyper-aroused clients to re-experience the safety of the 'window of tolerance', thus regaining trust in their ability to self-regulate and restore equilibrium.
Other factors crucial to creating a safe container for trauma work include: setting out a clear contract and therapeutic boundaries for the work, re-establishing the client's sense of control of his body and thus safety, and supporting the client in re-gaining connection with his own power and potential by working with his resources (Rothschild 2000: 88).

The fragmented narrative and the interrupted impulse

Having established the working alliance and some level of understanding of PTSD, identified a safe place and supported the client's resources, as well as gained some insight into D.'s traumatic developmental background, it was time to actively engage with processing the trauma. In our fifth session I invited D. to imagine himself in his garden, the place identified by him as safe. Together we welcomed the sense of calmness and expansion in his body evoked by the familiar images.

I then asked D. to tell me of the events that took place prior to the assault. In describing this, D.'s breath became shallow and he started showing signs of hyper-arousal. I asked him to stop and imagine himself back in his safe place, this time actively describing to him some of the images he had shared with me previously. After a few minutes, D.'s breathing stabilised and his body showed signs of relaxation.

Going back to the details of that evening, D. was now able to describe himself feeling scared and intrigued by the sights and noises of the gathering in the shopping mall. Soon

his body showed signs of hyper-arousal again, which I pointed out to him, naming the different bodily manifestations, and suggested that he 'go back' again to his safe place. As the level of arousal in his body reduced, I invited D. to tell me about the end of that evening, skipping the actual trauma itself. When his body began to show signs of hyper-stimulation, I invited him to gain control by imagining his place of safety again. D. expressed his appreciation for the rhythm of our work, which had enabled him to feel "for the first time as if there is hope for me, as if I could do this work and heal".

We continued working with this method for the next few sessions, narrowing the cycles of the story, until D. was able to tell me the full narrative and describe in detail what had happened before, during and after the traumatic event. His painful story was revealed in increasing detail, with events he had previously "forgotten" returning to complete the picture. As D. began to integrate the full story, his nightmares became less frequent and less overwhelming.

As we worked on the narrative of the trauma, we paid attention to spontaneous impulses in D.'s body. I encouraged D. to stay in contact with his body sensations and slowly he learned to express them in movements, words and images. A new connection was established between his body, until now largely disconnected and objectified, and his feelings, for which he was acquiring a language of symbols and images. D. was beginning to experience himself as a 'whole' being, and was able to engage more in the relationship with me. He began seeing me less as the 'medical expert' and more as the 'good mother', in whose eyes his emerging sense of self could be positively reflected.

The centrality of narrative to trauma work has been a point of consensus among practitioners of many approaches. It is through the re-telling of the narrative that the split-off fragments of the dissociated experience can be integrated and reclaimed, symbolisation can take place, and a sense of meaning and acceptance be gained. By sharing the details of the story, the client allows the therapist to bear witness to the pain, fear and humiliation which he experienced in isolation, to validate and normalise his feelings and celebrate his survival.
However, most PTSD clients find it impossible to re-tell the story without re-living it, thus causing re-traumatisation. Therefore, one of the aims of trauma therapy is to help the client to "be able to tell the story of the shocking event without totally reliving it" (van der Kolk 1996: 431). That implies monitoring closely hyper-arousal and dissociation signals, both of which indicate that the client is no longer able to distinguish between past and present and his sensorimotor system is flooded. The therapist's overall aim is, therefore, to work within the 'window of tolerance' [1].
There are many useful techniques to monitor and regulate the hyper-arousal during the process of narrative telling (Rothschild 2000, Levine 1997). In my work with D., I used the concept of the 'safe space' and the idea of working with the three stages of the traumatic incident - *before*, *during* and *after* the trauma (Rothchild 2000: 156); the therapist helps the client focus first on the less triggering parts of the experience, arriving slowly at the heart of the actual traumatic event. Working in this way, the client can reclaim the full experience of the trauma whilst having a sense of control over the process, which is crucial to this stage of the work.

Once D. had begun to tell his story and integrate some of its split-off fragments, he connected with what in body psychotherapy is called the 'interrupted impulse' i.e. the impulse to complete the vaso-motoric cycle towards expression, discharge and relaxation (Boyesen, G. and Boyesen 1981, 1982, see also chapter by Schaible). However, during a traumatic event, powerful enough to threaten survival, the charge accumulating in the system is much higher than in response to day-to-day stimuli. This level of energy cannot be discharged as long as the amygdala (limbic system) perceives the threat as ongoing and therefore continues to stimulate ANS reactions. As the ANS activates more physiological and biochemical mechanisms to deal with the perceived threat, the charge in the body intensifies beyond endurance. At this point, the process of dissociation kicks in, disconnecting the hyper-aroused energy from the person's awareness and thus preventing the

dangerous 'fullness' of the experience in the moment. So begins a self-perpetuating cycle in which the ANS is only able to recognise that the threat has passed when the accumulated energy is discharged, but no discharge can happen as long as the ANS is locked in its freezing response. The only way out of the cycle is to activate the SNS impulse (i.e. the fight-flight response) which is blocked under the 'lid' of the PrNS.

If the impulse towards expression and discharge is stopped or interrupted, the vaso-motoric cycle cannot complete itself and reach the relaxation stage. The impulse, however, does not disappear, as the energy inherent in the blocked cycle is constantly motivated towards completion. Rather, the interrupted impulse manifests unconsciously and non-verbally (e.g. in small movements or sounds, shifts in the breathing pattern or changes in the direction of the eyes). In D.'s case it took the shape of his right hand forming a fist. If this interrupted impulse is not followed and encouraged towards full expression, the blocked energy usually creates somatic disturbances. For D., this led to constant pain running from his right shoulder down his arm. However, as more split-off fragments of the traumatic event were integrated, the interrupted impulse acquired increasing force and presence, indicating that the blocked energy was more available and ready to be worked with.

Accessing and processing developmental trauma

With intimacy and trust deepening, D. began to share more childhood memories with me. It seemed that the growing connection between his body and its spontaneous impulses unlocked a gateway to more than just factual memories. D. was now experiencing in the sessions some of his early feelings, physical sensations and energetic states. Being in the room with him as he recalled his childhood, I had a clear sense in my own body of the degree of terror, pain, humiliation and helplessness that were his perpetual reality for so many years. Processing some of these early memories in parallel to his recent trauma, D. became aware of the close connection between them.

In our tenth session D. told me - noticeably agitated - of a dream involving an impatient, aggressive man who physically resembled D.'s father: he appeared from nowhere and cut off D.'s toes with a large axe. This dream precipitated a significant memory of an emotionally and physically abusive episode that took place when D. was 9.

Sensing how the relationship with the abusive father presented itself in the room at this highly charged moment, I invited D. to imagine his father sitting in the chair opposite him. D. was distressed, but not overwhelmed. It seemed that he carried in his body a felt sense of his resources, his power and his wholeness, all of which assisted him in addressing his internalised father as an external presence. What followed was a fifteen-minute 'two-chair work' (see chapter by Reynolds) in which D. told his father what he felt towards him as a child and as a growing adult, expressing in a clear and profound way all that had been blocked and suppressed for many years: his rage, shame, fear, humiliation and pain vibrated powerfully in the room, culminating in D.'s demand for meaning: "Why did you treat me like that? I was your only son, why did you hate me?"

We ended the session with a recall of the safe place and some of D.'s resources. After this session, he had a dream in which his father appeared, not disguised as somebody else, but clear and realistic; now his presence did not evoke fear or distress in D. During the following week, D.'s nightmares stopped, he was able to go out, and felt better than he had for a long time. Something profound had shifted in him. Now it was time to attend to the most persistent aspects of PTSD: flashbacks and psychosomatic symptoms.

The assault had unearthed some early and formative traumatic experiences. As D. regressed back to the frightened, helpless child he had been, memories of his abusive father and of specific traumatic events surfaced. When unprocessed developmental trauma is triggered, it is not possible to work through recent situational trauma without attending to the early layer first. As illustrated through research by van der Kolk (1996, 2002) and recent neuroscientific studies (Schore 1994, Damasio 1994), the infant's capacity for affect regulation and his ability to make contact are determined by the quality of his primal bond. A disorganised attachment will impair the child's ability to regulate states of hyper-arousal and will probably make these already traumatised individuals vulnerable to further traumatisation. When an early trauma is trigged by a recent event, it is therefore impossible for the client to regulate states of arousal during therapy, or use the therapeutic relationship as a potential resource until the early trauma has been addressed and contained.

During and after the assault, D. experienced similar feelings to those that characterised his relationship with his father: fear of annihilation, helplessness and unexpressed rage that turned into self-blame and depression. It is as if the recent event was a condensed snap-shot re-enactment of the violent abuse he had suffered for many years.

D. had remained unconscious of this link because he was attached to the 'bad object' (Fairbairn 1952). In his desperate need to preserve his attachment to his father, D. needed to dissociate from experiences and memories which might threaten that life-giving bond. This is a common defence among children who have suffered abuse at the hand of their primary care-givers (de Zulueta 2002: 56). As I began to provide the 'good mother' figure, including the support and containment that was missing in D's relationship with his frightened, obedient mother, D.'s growing attachment to me enabled him to shift some of the early attachment needs from his abusive father to the transferentially idealised mother-ally I became for him. This, then, enabled him to address his internalised father figure in a way that had not been possible before.

Of course, the dialogue with the internalised father did not constitute a thorough working-through of all the layers and implications of his developmental trauma. In working with D.'s suppressed anger we were addressing the top layer, which had become available to be processed at this stage. Underneath, I could sense a layer of primal longing for parental love and acceptance, which was unconscious in D.'s relationship with his father. This illustrates the splitting that often occurs in people who were abused as children between the 'good' and the 'bad' object (see Warnecke's chapter). In this case, all the 'good' was projected onto me and I became the carrier of the idealised parent. Working through this layer would require a longer process than I was able to offer within the constraints of the setting. However, I do believe that this session, being a fully embodied and expressive experience, was an important stepping-stone towards acknowledging and containing the early dynamics.

The second non-threatening dream of his father indicated that one of the many unfinished cycles in this abusive primary relationship had come to completion. I felt that D. would now be more available to process the recent traumatic event.

EMDR

> *D. felt more able to engage with his life and family and to distinguish between past and present events. Our work now focussed on his self-persecutory judgment of himself as "bad, weak and stupid". D. believed that he had 'caused' the assault by voluntarily stepping in to help the security guard. Feelings of guilt and shame fuelled his self-destructive rage. None of this was affected by verbal discussion as his negative beliefs were anchored in an early stage of development and carried primitive unconscious material, not amenable to rational reflection. I decided to use EMDR to process this part of the trauma.*

The part of the event that evoked most distress for him was the moment when he was squashed under a pile of bodies and felt he could not breathe. His negative belief about himself in recalling that moment was: "I am helpless, I am going to die". As we talked about it, the level of distress in his body rose. What he would have liked to have thought about himself in the peak of his distress was:" I will be helped, I will survive". Although this thought seemed unreal to him, he felt it to be comforting. As we focussed on his body sensations I was aware of the energetic charge escalating in his system. It was time to start our work with the eye movements.

EMDR (Eye Movement Desensitization and Reprocessing) was developed by Francine Shapiro (1989, 1995, 2001). In using this method, the therapist helps the client recall the memory of the trauma, starting with fragments of the experience which the client can recall readily: images, physical sensations and mental cognition. The therapist then provides some form of bilateral stimulation which can be achieved visually, kinaesthetically or auditorily.

What follows resembles a process of free association, as the client enters a dream-like state, in which images, memories and thoughts arise spontaneously. The therapist does not interpret or invite cognitive discussion of the material that surfaces into consciousness. After a while, clients usually report a noticeable reduction in their physical and emotional distress, recognising the trauma as a past event. This allows a more positive sense of self to replace the former negative cognition [2].

By introducing EMDR I was aiming to complete the process of retrieving split-off fragments of the trauma, and felt that we were ready to tackle what seemed to be the main obstacle to his recovery - D.'s sense of guilt and regret.
D.'s suicide attempt was an expression of 'survivor guilt' (Garwood 2002). As de Zulueta states: "By feeling they are to blame, they [the survivors] are at least feeling more in control of what has happened to them. It is a normal response in the face of the terrible sense of helplessness they experienced at the time of the traumatic event." (de Zulueta 2002: 55). She continues: "This 'moral defence'… is particularly prevalent in victims of childhood abuse and can best be understood by referring to research in the field of attachment." (ibid)

D.'s obsessive cycles of shame, guilt and remorse may have served, in a vicarious way, to maintain some sense of control, but they also perpetuated his negative belief about his helplessness and powerlessness, a belief he had carried since early childhood. No cognitive discussion could alter this belief as it was not based on a rational thought process. As long as D.'s sense of self was stuck in that guilt-ridden regressed position, he was unable to follow any of his body-impulses towards the fight-flight reaction, and thus his hyper-aroused system could not discharge.

Integrating EMDR and Body Psychotherapy

As we began processing the charged image with eye movements, D. felt tension in his body intensifying, and an overwhelming feeling of helplessness. He used the 'stop' signal we had agreed on, which gave him a sense of control and enabled him to choose to continue after a short break. We then did another 'set' of eye movements, and D. again experienced himself suffocating at the bottom of the aggressive heap. This feeling manifested in a rapidly growing charge in his arms and legs. I noticed signs of activation of the SNS (this time without the lid of the PrNS), and encouraged D. to sense the impulse in his arms and legs. He felt a strong spontaneous urge to kick with his legs and push with his arms. I stopped the eye movements and invited him to follow the impulse. D. did not need further prompting; within seconds he was standing in the centre of the room, pushing and kicking, shouting: "Get off me! Get off!"

His face was red, his hair disheveled, he had a wild look in his eyes. As he screamed "I will not let you do this to me! I am going to fight you back!" I realised that I was witnessing a transformative moment. A surge of energy that had been blocked and denied for many years was finding expression, and with it surfaced feelings that had perhaps been too dangerous to feel before: anger, aggression, assertion. D. did not need encouragement or approval; it seemed that he was celebrating his newly found sense of power and freedom. My role was to witness, my presence providing the container and safety for this spontaneous process. Gradually, D.'s breathing calmed, his face acquired its familiar colour, and his body relaxed. He realised that the target-image and negative cognition was far less real and threatening than it had been at the beginning of our session, whilst the positive cognition seemed to be more real.

D. said that when he was pushing and shouting he saw the young assailant's face (which until that moment had been a dissociated fragment) and that this image kept changing into his father's face, and than again into the assailant's face. For the first time D. was able to feel compassion towards the child he had been, unable to protect himself against his father's sadistic assaults, and to see clearly that the violent abuse was not his fault. The session ended after D. again recalled his safe place. His parting remark was: "I feel as if I have grown taller and wider, I feel so much bigger in my body!"

This session illustrates the power and potential of integrating several therapeutic approaches into the present moment. All the work we had done up to now came together, which enabled D. to break through layers of suppressed emotions and repressed impulses.

I could have continued to work solely with EMDR, rather then inviting D. to move into bodywork, because the way the session had evolved would have been clearly within the understanding and expectations of traditional EMDR practice. Indeed, many EMDR sessions with other clients have demonstrated to me that the level of distress in the system *does* subside, and had I chosen to continue EMDR work with D., the same would have probably happened.

What prompted me to integrate a body psychotherapy approach at that charged moment was my belief that for profound change to happen all fragments of the experience as well as all aspects of the person must come together and be felt and expressed (Soth 2005). In D's case, "all fragments of the experience" include his early developmental trauma which resulted in suppression of his healthy aggression and led to a distorted self image ("It is all my fault"), coupled with and echoed by the recent traumatic event in which he was again as violated and helpless as before. In re-experiencing the most highly charged moment of the latter, the two scenarios came together in the consulting room, manifest in D.'s vision of the faces of the two aggressors morphing into one another. Together, they reflected D.'s internal reality where the two traumas were being implicitly experienced as one.

At that significant moment, it was necessary to encourage what is always absent and fragmented in trauma: the embodied experience of feelings, images and cognitions coming together and being expressed in a relational context. As D. was standing in the centre of the room, shaking his fists against his aggressive father and the young attacker, many cycles came to completion simultaneously. Physically and energetically, the blocked fight-or-flight reflex was released from suppression by the PrNS, and the freezing reaction no longer stopped spontaneous expression. As this cycle of healthy reaction to threat was activated and completed, it appears that the various parts of the brain were able to resume their balanced activity; now D. was able to remember while connected to his feelings, and talk while differentiating between past and present.

At the same time, the stuck emotional cycle of D.'s blocked feelings towards his father found some completion as he was now able to do what had been impossible as a child: to stand up for himself and defend his rights for safety and respect. Transferentially, I think I was experienced then as a mother who did not need him to sacrifice his power in order to protect her, but who could be

present and welcoming as he celebrated it.

On a cognitive level, the stuck cyclic activity of the brainstem, which re-enforced the neurotic conclusion "It is all my fault" could now give way to an acknowledgement of the father's cruelty. The bringing together of *all* levels of the trauma, and the integration of D.'s newly found sense of himself, facilitated the transformation. The result of completing all the blocked cycles, on the physical, emotional and mental levels was a feeling of expansion.

Ending

> *Following this, the pain in D.'s shoulder disappeared, as did the numbness in his lower body. He had no further flashbacks or nightmares after that session, and felt able to resume his role as head of the family. He now took steps towards finding voluntary work. He looked alive and happy, and was able to repeat the narrative of the assault without feeling overwhelmed, keeping a clear differentiation between past and present. I knew we were approaching the end of our work together, as D. was no longer a PTSD patient.*
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> *With his newly-found confidence, D. was able to face one of the last triggers of post-traumatic fear. Together with his son, and later by himself, he went back to the location of the trauma. "It looked so ordinary", he told me, "just a normal shopping mall. I looked at it and felt normal myself."*
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> *By now D. was attached to me as the idealised 'good object' he had longed for throughout his childhood. In my countertransference I felt protective and loving towards his budding sense of worth and hope. Although I was aware that we had not processed all layers of transferential feelings, I trusted the good work we had done together.*

Conclusion

This chapter introduces an integrative model for trauma work, based on an integration of body psychotherapy principles with EMDR and attachment theory, the latter being one of the key factors in understanding complex trauma. My thinking was informed by neuroscientific research and an understanding of how the brain functions following trauma. I used guided imagery, Gestalt dialogue, resource building, tracking and body reading as well as Somatic Experiencing techniques.

Whilst a relational perspective (Davies & Frawley 1994) is part of my integrative model, in this case several layers of the transference remained implicit and unaddressed [3]. However, by closely monitoring my countertransferential responses, I stayed attuned to such transferential vicissitudes which informed my therapeutic presence throughout all stages of the work.

I have described elsewhere my model of change and integration in therapy (Heitzler 2004). For the purpose of this discussion, I believe that the key principles for integrated trauma work are:
- Working with the body
- Energetic attunement
- Attachment patterns
- Resolution of incomplete cycles
- Relational perspective

Many of the approaches discussed in this chapter are taught and practiced as comprehensive and complete methods of trauma work. I believe, however, that it was the flexible integration of all these principles into my work, coupled with D.'s courage and determination to heal, that enabled the process to unfold more fully towards change and transformation.

This chapter describes the unfolding of a relatively short and successful process, illustrating one possible way of working integratively with complex trauma. Although this case encapsulates my key beliefs and therapeutic principles, it is by no means typical, as I often experience frustratingly slow,

stuck or incomplete processes which challenge me on all levels.
Often, when working with trauma survivors, I feel as if I am called to bear witness to intolerable levels of human suffering. In writing this chapter I wanted to appreciate those privileged moments in which I was called to bear witness to the innate human capacity for healing and growth.

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[1] Current research, however, demonstrates the importance of working *at the edges* of the window of affect tolerance. In a talk given recently in London, Schore (2007) argued that only by working in a "safe but not *too* safe" way, inviting the arousal at the edges of the window of tolerance, necessary transformative enactments can occur in the therapeutic relationship, resulting ultimately in "expansion of the regulatory boundaries".

[2] Although there is as yet no satisfying detailed explanation for the rapid 'metabolising' of upsetting events prompted by EMDR, research has consistently proven its effectiveness (Mollon 2005). EMDR is now recognised by the National Institute for Clinical Excellence (NICE) as one of the major treatments for PTSD.

[3] e.g. the client's unconscious construction of the therapy and the therapist as the abuser (by which the therapeutic process itself is experienced as a re-enactment of the traumatising relationship)