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# COMPLEX POST-TRAUMATIC STRESS DISORDER:
## Putting the Pieces Back Together

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I have been thinking awhile about the kind of article I wanted to write on trauma. I was not sure I had something to contribute on this topic, because I do not have any substantial experience in dealing with clients who had come to me for therapy because of severe traumatic experience. But then, I started to read Judith Lewis Herman's book, titled Trauma and Recovery (1992) and I realized that many of my patients who had been sexually abused as children could fit the diagnostic of what she calls "complex post-traumatic stress disorder". I had found the angle from which I could tackle my subject.

In the first part of this article, I will summarize what Herman says about the traumatic experience, especially concerning prolonged, repeated trauma. In the second part, I will outline what she says about the recovery process and I will talk about how bioenergetics can be used in this process, at different stages.

### TRAUMA: THE AFTERMATH OF AN UNBEARABLE EXPERIENCE

"Complex post-traumatic stress disorder" is a term coined, I believe, by Herman and, it is based on seven diagnostic criteria, attempting to differentiate the syndrome displayed by people victims of circumscribed traumatic events (for example, survivors of plane crash, terrorist bombing, rape, war, natural disasters) from the syndrome found in survivors - most often women - of prolonged, repeated trauma (for example, survivors of childhood abuse, domestic violence, concentration camps). Herman believes that the latter have often been misdiagnosed in the past, because mental health professionals tended to view their problems in terms of their underlying psychopathology (Ex: somatization disorder, borderline personality disorder, multiple personality disorder) rather than in terms of adaptive responses to an abusive, unbearable traumatic environment.

In her well documented book, Herman refers to several studies to describe three kinds of typical symptoms survivors of traumatic situation (circumscribed or prolonged as well) are likely to suffer from. Those typical symptoms are hyperarousal, intrusion and constriction. Here is how she describes those symptoms:

**Hyperarousal**

Hyperarousal is a state of: "...permanent alert, as if the danger might return any moment. Physiological arousal continues unabated. In this state of hyperarousal, which is the first cardinal symptom of post-traumatic stress disorder, the traumatized person startles easily, reacts irritably to small provocations, and sleeps poorly." (p. 35).

**Intrusion**

Intrusion is a symptom related to traumatic memories: "Long after the danger is past, traumatized people relive the event as though it were continually recurring in the present. They cannot resume the normal course of their lives, for the trauma repeatedly interrupts. It is as if time stops at the moment of trauma. The traumatic moment becomes encoded in an abnormal form of memory, which breaks spontaneously into consciousness, both as flashbacks during waking states and as traumatic nightmares during sleep." (p. 37)

Referring to testimonies of survivors of Hiroshima and Vietnam soldiers cited in different studies, Herman also outlines the possible neurological impact of the traumatic situation: "Traumatic memories lack verbal narrative and context; rather, they are encoded in the form of vivid sensations and images. These unusual features of traumatic memory may be based on alterations in the central nervous system." (p. 38)

Because of the symptom of intrusion, people tend to replay the traumatic scenes not only in their dreams, but in their everyday life as well. Unlike child's play, which Herman describes as "free, easy, bubbly and light-spirited", the kind of play that follows trauma is "grim and monotonous". Moreover: "As opposed to ordinary child's play, post-traumatic play is obsessively repeated. In their attempts to undo the traumatic moment, survivors may even put themselves at risk of further harm." (p.39)

**Constriction**

Constriction has to do with reducing the range of one's consciousness in order to cope with the trauma. "When a person is completely powerless, and any form of resistance is futile, she may go into a state of surrender. The system of self-defense shuts down entirely. The helpless person escapes from her situation not by action in the real world, but rather by altering her state of consciousness." (p. 42)

Reactions of frozeness, numbing, dissociation and entering trance states are all typical of the phenomenon of constriction. According to Herman





"These perceptual changes combine with a feeling of indifference, emotional detachment, and profound passivity in which the person relinquishes all initiative and struggle. This altered state of consciousness might be regarded as one of nature's small mercies, a protection against unbearable pain." (p. 43).

Constriction symptoms usually start to predominate as intrusive symptoms diminish. In a way, they enable the traumatized person to resume her usual activities. She may appear to function better outwardly but, warns Herman, "...the severing of events from their ordinary meanings and the distortion in the sense of reality persists. She (the survivor) may complain that she is just going through the motions of living, as if she were observing the events of daily life from a great distance." (p. 48). One can appreciate the state of utter loneliness and alienation the survivor finds herself in: the very mechanism which enables her to "go on with her life" entraps her and prevents her from connecting with the rest of the world.

## TOWARDS A NEW UNDERSTANDING OF COMPLEX TRAUMA

As mentioned at the beginning of this article, the picture gets complicated with people who have survived prolonged, repeated trauma, especially in childhood. They are less likely to display typical post-traumatic symptoms similar to those defined just above. Consequently, they can easily be misdiagnosed and improperly helped as well.

Here is how this happens: "With patients who have suffered prolonged, repeated trauma, the matter of diagnosis is not nearly so straightforward. Disguised presentations are common in complex post-traumatic stress disorders. Initially, the patient may complain only of physical symptoms, or of chronic insomnia or anxiety, or of intractable depression, or of problematic relationships. Explicit questioning is often required to determine whether the patient is presently living in fear of someone's violence or has lived in fear at some time in the past. Traditionally, these questions have not been asked. They should be a routine part of every diagnostic evaluation.

When the patient has been subjected to prolonged abuse in childhood, the task of diagnosis becomes even more complicated. The patient may not have full recall of the traumatic history and may initially deny such a history, even with careful, direct questioning. More commonly, the patient remembers at least some part of her traumatic history but does not make any connection between the abuse in the past and her psychological problems in the present. Arriving at a clear diagnosis is most difficult of all in cases of severe dissociative disorder." (p. 157)

But even when the problem is properly diagnosed, the task of helping the survivors of prolonged, repeated abuse in childhood remains formidable, because we have to take into account the facts that if "Repeated trauma in adult life erodes the structure of the personality already formed, repeated trauma in childhood forms and deforms the personality." (p. 96) Consequently, a person who has been physically and/or sexually abused as a child will display a specific personality organization related to these conditions. Here are the main features that mark the lives of children who have been abused.

**Pathological attachment:**

Children victims of abuse will tend to develop pathological attachments, that is, attachments that "... they will strive to maintain even at the sacrifice of their own welfare, their own reality or their own lives." (p.98) This happens because they had no choice but to bond with their abusive caretakers and learn how to play their game in order to survive.

**Frozen watchfulness:**

Those children, "... while in a constant state of autonomic hyperarousal must also be quiet and immobile, avoiding any physical display of their inner agitation. The result is the peculiar, seething state of 'frozen watchfulness' noted in abused children." (p. 100)

**Social isolation**

Abused children find themselves in a social vacuum because their families are usually socially isolated, and because they are "...also profoundly limited by the need to keep up appearances and preserve secrecy." (p. 100) Because the whole pattern of communication is usually pathological in their immediate environment, they are isolated from other members of the family as well.

**Feelings of abandonment**

Very often, the "other" adult, the one who is not the perpetrator, failed to intervene. Thus, "The child feels that she has been abandoned to her fate, and this abandonment is often resented more keenly than the abuse itself." (p. 101)

**Doublethink**

Herman gives an impressive account of the "formidable developmental task" awaiting the abused child: she must learn to form primary attachment even though her caretaker is a dangerous person; she must develop a sense of basic trust and safety while her caretakers are untrustworthy and unsafe; she must develop a sense of self when she is in relation to others who are cruel, uncaring or helpless; she must develop a capacity for bodily self-regulation in a setting where her body is at the disposal of other's needs; she must develop a capacity for self-soothing in an environment without solace; she must develop her capacity for initiative in a situation which demands conformity with the abuser's needs; she must develop a capacity for intimacy when all her intimate relationships are corrupt and finally, she must develop an identity in an environment which defines her as a whore or as a slave. Along with this, the "existential task" of preserving hope and meaning in an environment in which she is abandoned "to a power without mercy" is equally formidable.





**Double self: the bad one/the good one**

In the process of trying to make sense of what is happening to her, the abused child starts to believe that if this horrible treatment befalls her, it is because she is bad. She feels rageful and aggressive, but she tries to camouflage this by persistently attempting to be good. She can become a "superb performer" and she will do whatever is required of her to be loved by her parents. "Thus, under conditions of chronic childhood abuse, fragmentation becomes the central principle of personality organization. Fragmentation in consciousness prevents the ordinary integration of knowledge, memory, emotional states and bodily experience. Fragmentation in the inner representations of the self prevents the integration of identity." (p. 107)

**Attacks on the body**

Since the abuse often causes disruption in regulation of bodily and emotional states for the child, the survivor is likely to develop chronic sleep disturbances, eating disorders, gastrointestinal trouble, and many other "bodily distress symptoms". To cope with this as well as with "dysphoria" - a dreadful feeling which is an undefined mix of terror, rage, despair and grief - the abused child will intensify the dissociative process. But, as Herman points out, "Instead of producing a protective feeling of detachment, it may lead to a sense of complete disconnection from others and disintegration of the self. The psychoanalyst Gerald Adler names this intolerable feeling 'annihilation panic'" (p. 108)

To alleviate this kind of panic and to soothe herself to some degree, the abused child will resort to self-destructive mechanisms. It is important to

understand that those mechanisms are seldom used to "manipulate" other people or even to communicate distress. Rather, they serve to regulate the internal emotional states: "Self injury is perhaps the most spectacular of the pathological soothing mechanisms, but it is only one among many. Abused children generally discover at some point in their development that they can produce major, though temporary, alterations in their affective state by voluntary inducing autonomic crises or extreme autonomic arousal. Purging and vomiting, compulsive sexual behavior, compulsive risk taking or exposure to danger, and the use of psychoactive drugs become the vehicles by which abused children attempt to regulate their internal emotional states." (p.109)

**When the child becomes a grown-up**

To sum up the situation, Herman talks about three major forms of adaptation a child develops when she has to cope with an abusive environment:

- the elaboration of dissociative defenses
- the development of a fragmented identity
- the pathological regulation of emotional states

Once the child has grown up, when she attempts to live her life and develop relationships with others, as an adult, all these mechanisms come into play. It is as though "She is still a prisoner of her childhood; attempting to create a new life, she reencounters the trauma." (p. 110)

The survivor's relationships will thus be marked by "...hunger for protection and care and haunted by the fear of abandonment or exploitation." (p. 111) She will tend to develop "...a pattern of intense, unstable relationships, repeatedly enacting dramas of rescue, injustice and betrayal." (p. 111) The risk of victimization in her adult life will be great. But we have to understand that repeated abuse is not actively sought "...rather it is passively experienced as a dreaded but unavoidable fate and it is accepted as the inevitable price of relationship." (p. 112)

Even if most abused children tend to become victims in their adult life, some survivors do become perpetrators. As could be suspected, research (Carmen, Reiker and Mills, 1984; Pollack, Briere, Schneider and al., 1990) supports the facts that: "Trauma appears to amplify the common gender stereotypes: men with histories of childhood abuse are more likely to take out their aggression on others, while women are more likely to be victimized by others or to injure themselves" (p. 113)





## RECOVERY: PUTTING THE PIECES BACK TOGETHER

In the second part of her book, Herman writes about the pathway to recovery. She insists that since the traumatic experience (circumscribed or repeated, alike), has led to disempowerement and disconnection, the healing process must focus on empowerement (or re-empowerment) and the creation of new connections with the environment. In this respect, the elaboration of a healing relationship with a therapist is a basic ingredient in the recovery process.

To be of a healing nature, this relationship must, first of all, give back the power to the survivor while supporting her efforts to control her behavior. The therapist is not there to control the patient. Instead, he/she should become, in Kardiner's words, an "assistant of the patient". By doing this, a safe and trustworthy relationship can develop between therapist and patient, and the healing can take place.

This is not without pitfalls, because the patient will likely establish a traumatic transference with the therapist, precisely because her personality has been "deformed" through her ordeal. The therapist must be aware that: "...traumatic transference reactions have an intense life-or-death quality unparalleled in ordinary therapeutic experience. In Kernberg's words, "It is as if the patient's life depends on keeping the therapist under control". The traumatic transference reflects not only the experience of terror but also the experience of helplessness." (pp. 136-137)

In this kind of transference, the therapist will experience strong destructive forces that will repeatedly intrude in the relationship and disrupt it. According to Herman, these strong disruptive forces are a reflection of the perpetrator's violence rather than the innate aggression of the patient. As the traumatic transference takes place, strong counter-transference reactions will be elicited. The therapist will experience frustration when faced with repeated disruption in the relationship with the patient; he/she will cope with feelings of helplessness, rage and despair leaving him/her with the impression of being "deskilled" while having to resist the temptation to play the role of the rescuer, at the same time (which would, in fact, disempower the patient and merely serve to defend the therapist against helplessness, rage and/or despair). The therapist may even start to experience symptoms of post-traumatic stress disorder himself/herself and may also be tempted to act out his/her sadistic impulses and become abusive in many subtle ways.

This is why it is so important that the therapist make a contract with the patient in order to provide a frame, a "container", that will help manage

the intensity of transferential and counter-transferential reactions. Kernberg insists on this as well, when he explains how to work therapeutically with borderline patients (who have been victims of childhood abuse, most of the time). Because of the effect of traumatic transference, it is equally important for the therapist to take care of his/her emotional health by joining a support system of colleagues and/or teachers who can help him/her maintain good boundaries and develop a sense of perspective regarding the therapeutic situation. As therapists, we have to know that it is necessary to take care of these aspects if we want the recovery process to take place in a healthy and secure setting.

Herman defines three main stages of recovery for survivors of traumatic situations (circumscribed and prolonged, alike):

- Establishment of safety
- Remembrance and mourning
- Reconnection with ordinary life

In the next part of my article, I will explain what each stage is about, I will look at them from a bioenergetic perspective, and I will talk about the kind of work that can be done with childhood abuse survivors at each stage, bioenergetically speaking.

**First Stage: Establishment of Safety**

The establishment of safety is a prerequisite to any therapeutic work done with survivors of childhood abuse. This goes hand in hand with helping the survivor regain some power over her life. Herman mentions a certain numbers of ways in which this can be done:

**Naming the problem**

Naming the problem is crucial, especially with victims of prolonged trauma who had to distort reality in order to survive. It is crucial because "knowledge is power". Knowing that one was not crazy to feel the way they felt is tremendously important.

With several of my female clients who have been sexually abused, I could see how empowering it was when I would encourage them not to dismiss their feelings and sensations on the assumption that it was "crazy" to feel that way. In order to help them validate those sensations and feelings, I would talk in terms of different "versions" of their story. I would say that although there always was an "official version" of their story, (usually the one carried in the family), there was also a "hidden (or lost) version" buried in themselves, in their bodies, that needed to come to light. Because





I would tell them over and over again not to dismiss their sensations, feelings, emotions or thoughts, in relation to their past, my patients would often begin to piece together a different "story", much more connected with what they had always felt was "true". Even in this initial phase, in many small ways, the traumatized child tries to break through a barrier to tell her story to someone who can hear, and the more the therapist validates this inner voice, the more the patient can acknowledge and make space for the traumatized child.

**Restoring control**

Restoring control, first in the body and then in the immediate environment, is equally crucial to the recovery process. Herman suggests that in certain cases, the use of medication may be advisable in order to reduce reactivity and hyperarousal. She also suggests the use of behavioral techniques or hard exercise to reduce stress. Finally, she teaches the survivor how to map her progress on a daily basis, how to chart her symptoms and adaptive responses, and how to develop concrete safety plans.

**Establishing a safe environment**

According to Herman, the survivor will gradually shift her focus from the control of her body to the control of her environment. This is why the therapist should help his/her patient establish a safe environment by cultivating caring relationships. The therapist should be equally concerned with the development of a plan for future protection with patients who tend to put themselves in jeopardy without realizing it. In case or survivors of prolonged, repeated trauma, Herman points out that "The sources of danger may include self-harm, passive failure of self-protection and pathological dependency on the abuser. (...) In the process of establishing basic safety and self-care, the patient is called upon to plan and initiate action and to use her best judgement. As she begins to exercise these capacities, which have been systematically undermined by repeated abuse, she enhances her sense of competence, self-esteem and freedom." (pp. 166-167)

## CREATING A SAFE THERAPEUTIC ENVIRONMENT IN BIOENERGETICS:

**A Question of Control**

In Bioenergetics, we have wonderful therapeutic tools to help survivors of childhood abuse regain more control over their body. The delicate part is to find how to introduce body work in the therapy setting in a way

that will not only be safe and empowering to the patient, but in a way that will feel safe and empowering to her as well. Here are different ways in which I approach body work with some of my patients who are childhood abuse survivors, in order to help them restore some degree of control over their process:

**• I let the patient monitor the distance and decide how she would like us to sit in the room**

Some of my clients are very sensitive to distance whereas others are not, because they simply do not sense their boundaries. For those who are, I suggest that they pick a place in the room where they will feel safe and I ask them to tell me where to sit in order for them not to feel invaded. I often remind them to pay attention to their body responses (breathing, tensions and any other bodily experience) as a way to check out if the distance is okay for them. At the same time, I try to stay aware of micro-movements in their face and body (tightening of the jaw; clenching of teeth, of fists; reduction of breathing; shifts in the eyes; etc.) and I feed them back the information, especially for those who need to develop more self-awareness.

**• I ask permission to touch**

As a rule, I never touch my patients without asking permission, but I am doubly aware of the need to be granted permission to touch when I work with incest and childhood abuse survivors.

**• I let the patient decide how she will dress to do body work**

Childhood abuse survivors need to have some control over how they will dress to do body work. That is not to say that their resistance to undress must not be pointed out and analyzed, but this resistance should also be understood as an attempt to protect themselves against further exposure and abuse. It is necessary that the decision to take off clothing be theirs. I have a very cooperative client, who has been sexually assaulted as a child, who is very willing to do body work and who works very well indeed, but she could never bring herself to work in a bathing suit or in underwear. She elected to do body work in shorts and tanktop, and the fact that she still insists on wearing this outfit rather than giving in to my initial suggestion of wearing a bathing suit is clearly seen by both of us as part of a process to regain power over her body. She is simply saying no to something she would experience as abusive, for now.





As we all know, childhood abuse survivors are in great need to be loved and approved and many of them do not have a clear sense of their own boundaries. This is why we have to be sensitive to the clothing issue. Most of the time, we have to make these unbounded patients aware of the fact that their compliance with the standard requirement to undress may indicate that they are giving their bodies away to the therapist, either to gain love and approval from a strong parental figure, or to be magically cured by some omnipotent god-like figure, or merely because they feel that their opinion and feelings are negligible. Not much will happen during body work if we overlook this, because the patient will probably dissociate. Once she gets back home though, she may very well be flooded with feelings of distress, rage and shame, and she might find herself unable to cope with those feelings alone.

**• I use pushing back exercises to establish boundaries**

Any exercise which calls for maintaining a boundary or for pushing back with hands or feet or with the back may be a good starter, provided that the patient agrees to experiment with it. But some of the survivors might not push very hard neither very long, at first. For them, the mere gesture of setting a limit and reclaiming their space may be very frightening, and the emotions elicited may be overwhelming. But it may be enough for them, at first, to merely put their hands against mine to feel their boundaries or to slightly push against me . Used over and over, this kind of exercises can help patients build their ego strength. Moreover, it lays the ground for the development of feelings of safety, in the therapy setting as well as in the world. It needs to be said though, that helping the patient establish boundaries and reclaim her space is not only a matter of techniques, and the attitude of the therapist must permit limit setting not only during exercises, but in the rest of the therapy as well. Sometimes, patients will find their own ways of pushing back the therapist: they may decline to do an exercise, or refuse to comply with a set of instructions; they may reject some of our interpretations; they may complain that we are being intrusive, etc. When that happens, we must support the expression of their subjective experience, but at the same time, we must persistently interpret their reaction in terms of character structure, while acknowledging the part of reality that triggered their reaction (there is never smoke without fire...). No small feat!

**• I give homework**

At the end of a session, I very often suggest exercises to do at home. Usually those exercises will have been experienced during the session, but new ones can be added if the patient feels at ease to try them on her own. The purpose of this is of course to help the patient regain her body. Because survivors of childhood abuse had to shut off or numb their bodily sensations very early in life, we have to look at homework as a reeducational process. Regular body work will bring them back into her body and though mostly tensions may be felt, at first, patients will gradually learn to reclaim their body, however painful it may be. After all, their body is their "home". But patients may be equally surprised to discover some pleasurable sensations as well, when they increase their breathing and when they release their tensions through some of the exercises. Lowen's book, The Way to Vibrant Health suggests a whole array of exercises patients can use on their own. We have to follow up on the homework, though, to have a sense of how the patient experiences the "homework" and of which of the exercises are most profitable to her.

## SECOND STAGE: REMEMBRANCE AND MOURNING

At this stage, the survivor tells her story. The story of the trauma must be remembered and reconstructed in order to transform into a memory that will be integrated into the survivor's life. In this process, the survivor gets in touch with her grief and mourns her losses.

### Reconstructing and transforming the story

The initial account of the traumatic story may be repetitive and somewhat static, but gradually, the survivor is helped to confront the horrors of the past and face the sensations and emotions connected with the traumatic story. This is a delicate task because: "As the survivor summons her memories, the need to preserve safety must be balanced constantly against the need to face the past." (p. 176)

According to Yael Danieli, a therapist who wrote about the Holocaust survivors, finding out about the earlier history "re-creates the flow" in the patient's life. As Bioenergetic therapists, we know as well that "re-creating the flow" in the body, through body work and character analysis, will help the patient get in touch with her story.

During the stage of reconstruction, the therapist must remain "neutral" in certain ways: "As the therapist listens, she must constantly remind herself to make no assumptions about either the facts or the meaning of the





trauma to the patient.(...) Both patient and therapist must develop tolerance for some degree of uncertainty, even regarding the basic facts of the story." (p. 179)

At this stage, "The fundamental premise of the psychotherapeutic work is a belief in the restorative power of truth-telling." (p.181) The story then becomes a testimony, which gives a new and a larger dimension to the patient's individual experience.

### Mourning traumatic loss

Mourning is an essential component in this healing process. This is why the therapist should not get caught in the role of the rescuer, because it would take away from the patient the possibility of working through her grief. According to Herman: "Only through mourning everything that she has lost can the patient discover her indestructible inner life". (p. 188) But she also adds that: "Since mourning is so difficult, resistance to mourning is probably the most common cause of stagnation in the second stage of recovery. Resistance to mourning can take on numerous disguises. Most frequently it appears as a fantasy of magical resolution through revenge, forgiveness, or compensation." (p.189) This is why: "The second stage of recovery has a timeless quality that is frightening. The reconstruction of the trauma requires immersion in a past experience of frozen time; the descent into mourning feels like a surrender to tears that are endless." (p. 195)

Herman says that there are no fixed answers as to how long it will take, but she believes that the process cannot be bypassed or hurried. After many repetitions, however, "...the moment comes when the telling of the trauma story no longer arouses quite such intense feeling. It has become part of the survivor's experience, but only one part of it." At last, "...the time comes when the trauma no longer commands the central place in her (the survivor's) life." (p.195)

## REMEMBRANCE AND MOURNING THROUGH BIOENERGETICS:

### A Question of Containment

Most certainly, because we work to restore the flow of energy in the organism, we cannot help but awaken memories that have been buried in the body through chronic tensions. Nevertheless, it may take long for a patient to integrate all the components of her experience. Sometimes the story will surface only in terms of body sensations. The feelings remain cut off, and there will be no images, no words, to give meaning to what is happening. For instance, the body might start to twitch or go into spasms,

desperate cries may come out, but even if this looks like an intense cathartic experience from the outside, from the inside, the patient may not have access to her feelings or to an understanding that would make her fully experience what is going on.

As bioenergetic analysts, we have powerful tools to help a patient break through barriers of amnesia to retrieve pieces of her past experience. But our task does not stop there and our role is to help the patient re-establish a continuity in her body, in her memory and in her emotional life, as the material surfaces. As we assist our patient through reconstruction, we have to be aware that for each piece of traumatic experience that surfaces, there is a certain amount of explosive energetic charge that has to be dealt with and integrated in the body as well as in the psyche. It is often difficult to predict how the material will surface and at what pace. Sometimes an event that looks insignificant can trigger a crisis: a particular expression on the therapist's face; a failure on his/her part to notice distress in the patient; a bad timing with an exercise; an appointment that has to be cancelled because the therapist is sick or because he/she is going away, all those being "failures" may elicit rage, panic, or deep sadness. Through these crisis situations, however, the story is being re-told, but this time, instead of letting the patient cope all by herself with the intensity of the feelings, the therapist is there to help her analyze and contain her experience.

This is why I would say that the key bioenergetic concept for this stage of recovery is the concept of containment, and in Bioenergetics, there are different ways in which we can help a patient retrieve traumatic memories and develop more capacity for containment:

**• Work gently with the frozeneness and with the splits**

Any kind of body work that brings energy to frozen areas of the body or restores connections in parts of the body that are otherwise split is likely to elicit traumatic memories. This kind of work has to be done with care and special attention must be given to integration and grounding.

**• Decipher the body to give meaning to the experience**

Body reading is a precious diagnosis tool. Ideally, body reading should be done when the patient is in a bathing suit or in underwear, so that we are able to see the color of the skin, the exact shape of the body, the tenseness of the muscles, the depth of the breathing, etc. But with childhood abuse survivors, this may not always be possible.





Nevertheless, we work with what we can see and if the patient needs to remain clothed, we may ask permission to put a hand on her chest or on her belly, and in her back, for example, to appreciate the depth and quality of the breathing and feel the rings of tension that split the body. The patient can help in this process. She can give informations regarding health problems (ex. gastrointestinal or vaginal problems) that can be telltale signs of alienation of certain parts of the body, or she can report constrictions in her body that will give the therapist some sense of where the major block are and how severe they appear to be. This, in itself, should tell a story about how this patient survived and about the particular pattern of splits the was "chosen", so to speak, by the organism to face the traumatic environment.

For example, my patients who had a mother who was either very cold or depressive and an abusive father, tended to be thin and very tense, somewhat like Lowen's schizoid character type, whereas the patients who had an invasive mother and an incestuous father, as well as those who had an abusive mother and an absent father, tended to look more like the masochist type, but with bodies had an unbounded quality rather than an overbounded quality, as the typical Lowenian masochist is often described.

Looking at the body in motion also tells a lot. I have often noticed that whenever the charge increases in the body (through deeper breathing, or even through verbal work on transferential contents), the body of childhood abuse survivors will tend to twitch and go into spasms as though it is trying to free itself from a trap. The particular kind of twitching and spasms that seizes the body is a language in itself saying: 'Look what was done to me[a].

For example, if the body writhes but if the shoulders appear to be pinned to the mattress, it may indicate that the perpetrator used to pin down the child by the shoulders. When gagging happens, not infrequently does it tell a story of the child having had something put in her mouth while the abuse was taking place. Whether the therapist should share his/her perception of the story, at this point, or wait for the patient to retrieve the memory by herself is a matter of clinical judgment. In any case the therapist should be very cautious not to impose a story, because it could only be another "version" which might take the "true story" 1 away from the patient. The story that the patient painstakingly reconstructs for herself is the only valid story. The therapist is there to help her get to the bottom of her true story, but under no consideration should he/she insist that the patient accepts his/her "version" as the valid one.

• **Connecting the voice with the body**

Often times, childhood abuse survivors will have trouble making sounds or saying words aloud with the intensity and the emotional charge they feel inside. All of my patients who were survivors of childhood abuse reported, at one time or another, that they were literally screaming their heads off inside, while they were unable to make an audible sound during body work.

Almost without exception survivors of childhood abuse have no voice, either because this part of their body has been assaulted at an early age, or because they had to keep "the secret", in the case of incest survivors.

To help open up the voice, one may instruct the patient to inwardly hear any cry or any word that may come, during the work, and to report on them. Another possibility is to instruct the patient to let a soft sound out, without pushing it. It does not have to be a big sound, but it has to go all the way through until all the air has been breathed out. Sometimes deep sobbing will come from this, and the patient may get in touch with deep sorrow and with grief, buried under layers of rage, sadness and panic.

• **The importance of holding in the process of building a container**

Survivors of childhood abuse often pose a particular problem, energetically speaking. On one hand, there is a high degree of charge in their body when they connect with a painful memory, but on the other hand, the possibility of discharge is greatly reduced due to the absence of voice and to the frozeneness of the body. Survivors have been terrorized, overtly or covertly, and their bodies have learned to keep still in order to survive. They would rather go dead than face the aggressor. Intellectually speaking, they are aware that their fear is irrational, that it may be the fear of a one-year old or of a two-year old child, or even that of a few months old baby, but at the gut level, they are facing an all-powerful, cruel being, who has the means to destroy them.

The only way to help these patients unfreeze and start to release what has been kept inside is to stay with the process without pressing. One cannot push the river. It flows. These patients need to feel supported and protected through their process of remembering and mourning, and when their experience become too scary or too invasive for them, we may silently hold their feet, their hand, their neck and head or their back, to help them thaw and express themselves. This simple contact provides a human presence in an otherwise inhuman inner world, full of threatening figures.

Ideally, we should try to help patients get in touch with their traumatic memories in a way that makes their experience manageable. Nevertheless,





emergency situations may happen when the ego is not strong enough to contain the intensity of an experience. Patients may be suddenly flooded with memories and feelings so intense that they find themselves on the verge of disorganization. In such moments, containment is needed from the outside and the therapist may need to act as a container. One way to act as a container is to instruct the patient to wrap around the therapist, in a foetus-like position, while the therapist puts one hand on her neck and the other on her lower back or on her feet. This is one of several ways that enables the client ground through the body of the therapist. We must remember that a survivor may need to go through this phase before planting her roots in her own ground.

• **Grounding, grounding, grounding**

It goes without saying that a lot of work needs to be done on grounding, in a more "classic" way, at this particular stage of recovery. Rubbing feet against the floor; digging toes into the ground; working on the ankles; putting one's weight on one leg, then on the other; kicking or pushing with the legs; frequently coming back to the bending over position; pushing against the therapist's hand, from the feet, in the bending over position are all but a few of many strategies that can be used to strengthen the patient's ego. This work needs to be done in order to increase thgLcapacity of the organism to cope with traumatic memories that will surface during this stage. Opening up the flow of energy in the legs, will increase the connection with the ground, and when we do this, we are helping the patient develop a secure basis, a "good inner parent" able to keep on taking care of the traumatized child once the therapy is over.

## THIRD STAGE: RECONNECTION WITH ORDINARY LIFE

In this stage, the survivor of a traumatic experience learns how to regain power in real life situations and how to face the future. In Herman's words: "Having come to terms with the traumatic past, the survivor faces the task of creating a future. She has mourned the old self that the trauma destroyed; now she must develop a new self. Her relationships have been tested and forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must face anew a sustaining faith. Survivors whose personality has been shaped in the traumatic environment often feel at this stage of recovery as though they are refugees entering a new country. They must build a new life within a radically different culture from the one they have left behind." (p. 196)

This reconnection with ordinary life will happen through the mastery of different aspects. Herman outlines some of them:

**Learning to fight**

Learning to fight may involve self-defense training as well as learning how to confront social pressure that keeps the survivor in a victim role in the present. It may also involve confrontation with the abuser and with the family, but, as Herman points out, they have to be "properly timed and well planned". The survivor must be ready for it and must not undertake it for revenge.

**Reconciling with oneself**

Herman believes that "This simple statement - "I know I have myself" - could stand as the emblem of the third and final stage of recovery." (p. 202) Reconciling with oneself also "...requires repudiating those aspects of the self that were imposed by the trauma. As the survivor sheds her victim identity, she may also choose to renounce parts of herself that have felt almost intrinsic to her being. Whereas in the past survivors often imagined that ordinary life would be boring, now they are bored with the life of a victim and ready to find ordinary life interesting." (p. 203)

Finally, self acceptance can come only when the survivor starts to take charge of her new life: "The more actively survivors are able to engage in rebuilding their lives, the more generous and accepting they can be towards the memory of the traumatized self." (p. 203-204) At this stage, the survivor develops a new sense of pride and sometimes she can even "...identify positive aspects of the self that were forged in the traumatic experience, even while recognizing that any gain was achieved at far too great a price." (p. 204)

**Reconnecting with others**

Reconnecting with others involves the capacity for the survivor to feel autonomous while remaining connected to others. Herman sees this in her ability to "...maintain her own point of view and her own boundaries while respecting those of others. She has begun to take more initiative in her life and in the process of creating a new identity. With others, she is now ready to risk deepening her relationships. With peers, she can now seek friendships that are not based on performance, image, or maintenance of a false self. With lovers and family, she is now ready for greater intimacy. The deepening of connection is also apparent within the therapeutic relationship." (p. 205)





**Finding a survivor mission**

Finding a survivor mission may be a way, for a significant minority of people who have been victim of traumatic experience, to come to a resolution. As Herman says: "While there is no way to compensate for an atrocity, there is a way to transcend it, by making it a gift to others. The trauma is redeemed only when it becomes the source of a survivor's mission." (p. 206).

For a survivor, finding a mission might have to do with social action, but with legal action as well. When it does, "Her (the survivor's) particular battle becomes part of a larger ongoing struggle to impose the rule of law on the arbitrary tyranny of the strong." (p. 211) At this stage, action is taken in a very healthy and realistic way, because the survivor's "...recovery is based not on the illusion that evil has been overcome, but rather on the knowledge that it has not entirely prevailed and on the hope that restorative love may still be found in the world." (p.211)

**How to know that the patient has come to a resolution**

Herman believes that: "Though resolution is never complete the best indices of resolution are the survivor's restored capacity to take pleasure in her life and to engage fully in relationships with others." (p. 212) She also cites Mary Harvey, a psychologist, who defined seven criteria for the resolution of trauma:

1) The psychological symptoms of post-traumatic stress disorder have been brought within manageable limits;
2) The person is able to bear the feelings associated with traumatic memories;
3) The person has authority over her memories: she can elect both to remember the trauma and to put memory aside;
4) The memory of the traumatic event is a coherent narrative, linked with feeling;
5) The person's damaged self-esteem has been restored;
6) The person's important relationships have been reestablished;
7) The person has reconstructed a coherent system of meaning and belief that encompasses the story of the trauma.

## RECONNECTION WITH ORDINARY LIFE THROUGH BIOENERGETICS:

**A Question of Mobility**

As we all know, Bioenergetics has been developed to help people restore the original life pulsation through their body and through their whole

being. This means that Bioenergetics wants to free the individual from the repetitive programmed responses of his/her character structure so that he/she can respond in a spontaneous, joyful, adapted way to everyday life situation. With its emphasis on grounding, Bioenergetics wants to help the patient to stand up and be assertive in contemporary society as much as it wants to help him/her surrender to his/her deeper feelings. Consequently, as bioenergetic analysts, we can do meaningful work with patients in their third and final stage of recovery.

If containment was the focus of the second stage of recovery, mobility should be the focus of the third stage. This means that we are going to help the survivor develop her ability to fight back as well as her ability to reach out. It also means that we are going to help her restore mobility in her whole body, but more specifically in her pelvis segment, so that she may own and enjoy her sexual power as fully as possible.

**• Freeing expression through playfulness**

In the last stage of recovery the patient, having faced her inner monsters, is now more active in her own process. She may feel like and adolescent looking up to a loving parent, expecting guidance on how to become an adult. The therapist is less of a parental figure at this stage, and more of a role model for the patient who now feels free to assert herself in her resemblances as well as in her differences. To allow the healing process to take place, the therapist has to acknowledge the personal growth he/she sees in his/her patient. It is a good time to help the patient consolidate a healthy narcissism by mirroring the new strengths and qualities developed by her.

Apart from the question of role model, there is still much work to be done at this stage. For instance, breathing might still need to be opened up, to increase the patient's potential for pleasure and enjoyment. Blocks in the shoulder and in the jaw segments also need to be worked with in order to free the aggressive and the reaching out impulses, as well as the biting and sucking impulses. At this stage, the breathing stool may be used more frequently. In the third stage, the expressive work is not so much centered on the release of explosive emotions repressed in the past. Rather, its purpose is to deepen and broaden the range of expression in the patient's present life. Not infrequently, at this stage, the therapeutic work becomes more playful and less dramatic.

**• Reclaiming sexuality**

Sexuality is a center piece in the personality. Because so many survivors of childhood abuse have been deeply wounded sexually, we must help





the survivor reclaim her sexuality. The work will certainly involve the pelvic segment at this stage. Exercises like falling, bridging, pushing with the pelvis against a pressure, energizing the devil, may be used to help the patient gain more ego strength, on one hand, while helping her to surrender to her sexual energy, on the other hand (see Bennet Shapiro's document titled Healing the Sexual Split Between Tenderness and Aggression which presents a good sequence of exercises).

This is not easily done, because the wounds around sexuality often run very deep and to surrender to sexuality may be negatively experienced by the survivor. She may feel that she is once again an object manipulated by an abuser. This kind of feelings may surface even if the survivor's sexual partner is a loving, tender and respectful person. To tackle this problem, the therapist must use a two-pronged approach: 1) sustained work on boundary setting, self-assertion and self-expression, in which the ego is active and fully in control (usually in the standing up position), and 2) work on letting go, in which the ego surrenders to a deeper movement of energy, as happens in orgasm (usually in the lying down position).

## CONCLUSION

If Herman's book gives us landmarks to find our way through the process of helping a patient suffering from complex post-traumatic stress disorder, we still have to find a path for each single patient.

We certainly need to be inventive and to adapt our therapeutic approach to our patients, for their process sometimes unfolds in an unpredictable way. Although Herman defines stages in recovery, she also says, at the end of her book that: "The course of recovery does not follow a simple progression but often detours and doubles back, reviewing issues that have already been addressed many times in order to deepen and expand the survivor's integration of the meaning of her experience." (p. 213)

I like to keep in mind that although these stages of recovery follow one another, broadly speaking, the patient will most likely go through the stages in a spiral-like movement. Any time during the process, she may regress to earlier stages in the therapy, when she faces stressful experiences in her present life, only to dash forth when she feels more secure. Chances are there will be micro sequences taking place in the larger sequence. Life does not follow a predetermined linear path, after all.

Perhaps this is all for the better, because it demands that the therapist responds to his/her patient's suffering in a unique way, with his/her resources of creativity, compassion and insight. This is what shared human

experience is all about.

And this is precisely what the survivor needs for her to heal.

**Montreal, June 21, 1993**

## FOOTNOTES

1. What I mean by "true story" does not refer to what actually took place. Rather, it refers to how the child experienced what was being done to her, and to her true feelings regarding the abusive situation.

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