Human Trauma

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I would like to acknowledge Maryanna Eckberg for her work that has taught me a great deal about trauma. I am thankful for the grace, the intelligence and the brave and generous heart that she shared with us. I am also grateful to Michael Maley for his clarity and generosity of spirit when I have had trouble living in the question.

Note; For convenience, I will be using the masculine personal pronoun in this talk.

Peter Levine's Somatic Experiencing challenges us in Bioenergetic Analysis in a number of ways:

A. To look carefully at whether we are re-traumatizing our Bioenergetic patients by encouraging the expression of overwhelming emotion- that is, by using a rigidly cathartic model.
B. In a related concern, Helen Resnick (1993) invites us to consider how many of our patients remain bonded to us for fruitless years of therapy in which the Stockholm Syndrome is being played out via a perpetrator transference/counter-transference dynamic. As you may know, the Stockholm Syndrome is a term describing people who remain in abusive relationships because they are bonded with the abuser.
C. Peter Levine's work makes me question how often our Bioenergetic work engages the patient's traumatic experience as it lives in their body...how often our work finds, as Phil Helfaer puts it, the patient's spontaneous inner movement. It is good to ask ourselves such questions.
D. We are also challenged to better clarify the difference between what Levine calls shock trauma and what many of us in bioenergetics call developmental or character-based trauma
E. Somatic Experiencing also invites us to rethink the kinds of positive resources we help our Bioenergetic patients to find by themselves and within themselves - I mean, for instance, their inner dance, their brave gesture, the resonance of their voice, a safe place--resources to help them better cope with the trauma that has broken them.
F. Finally, we are taught by Peter Levine to be more aware of the traumatic episodes in our patients' histories. He alerts us to apparently minor falls, accidents, so-called routine medical procedures that are actually hidden causes of debilitating traumatic symptoms, often many years later. After reading Levine's work, I find myself better able to grasp the impact of such, often isolated, events. My own Bioenergetic training, in contrast, focused on traumatic events that were embedded in a dysfunctional family of origin.

On the other hand, and in the spirit of dialogue that we hope will inspire our Montebello conference, Bioenergetic analysis, as I understand it, challenges Peter Levine's work in the following ways:

Is it really true - is it even possible that a particular approach, whether it is Somatic Experiencing, Bioenergetic Analysis, EMDR, etc., can be the optimal approach for treating trauma in the infinitely varied and complex creatures we call our patients? I think not. First, let me mention a few obvious reasons:

1. An approach developed by Peter Levine, or Bob Lewis, or anyone of you, may be an optimal approach for Peter or Bob with their gifts and their limitations, and, more precisely, this optimal approach will keep evolving as Peter's and Bob's gifts and limitations keep evolving.
2. Then there is the question of what is optimal for the patients at a particular point in their life with their unique mix of gifts and limitations. The same general approach, for example, is not likely to be optimal both for patients who flood all too easily with emotion and for patients who have little access to their feelings.
3. Even if we are reluctant to look at our failures, as therapists, we do develop reputations for working in a certain way, and the patients who seek us out, tend to confirm the style and method of doing therapy with which we are comfortable. I believe it was Feldenkrais who said that the only case histories worth reporting were those in which we had failed.
4. Peter Levine's writings and his talk today are understandably about patients who do beautifully with his approach, often after many years of suffering and many other therapies. This is exciting and this is why we invited him. Since I am the respondent, however, my talk is going to be about the kind of patient who is almost universally agreed to be the hardest to help, and who, when he does get better, does so slowly and painfully, regardless of who is treating him and with what method. I am speaking of the patient whom most of us know all too well: the chap with the history of early developmental trauma as a daily betrayal at the hands of his family of origin - that is, his primary attachment figures. I will be arguing in this paper that the Stockholm Syndrome presents at least as much of a challenge to Levine's model as it does to Bioenergetics. Both hostages and Rhesus monkeys teach us that when danger threatens, exploration is abandoned in favor of seeking proximity to an attachment figure. But what they do not teach us is what to do when our body's flight response propels us back to the traumatic danger!
5. I believe, as I believe most Bioenergetic therapists believe, that each trauma survivor is a real person and that therefore what is optimal for each such patient is a totally unique mix on a continuum of catharsis and containment. The heart of the matter is his encounter with his inner being and who you, the therapist, really are.

Let us look carefully at the challenges such a patient presents:

A. How relevant is an ethological model to human beings? We have much to learn from animals, from nature and from our animal nature. But can we really ignore the many thoughtful students in this field who have warned us about the danger of drawing inferences from one species to another without due respect for the differences between them? I am suggesting here that for the kind of patient whom I often see in my practice, who presents a complex interweave of developmental and shock trauma, we need a richer, or more complex model than that provided by Levine's Somatic Experiencing.. For instance, our model needs to be informed by attachment theory and research, another ethologically derived way of viewing people that actually stands up when tested by science (it is both clinically relevant and scientific in that it can generate hypotheses which can be proved incorrect or correct.) As Bowlby conceived it, the biological purpose of the attachment system was protection from predators. Infants and small children must stay close to their mothers at all times and must signal separation if they are to remain safe from predators. Clearly, any threat to this system is, by definition, a threat to life, that is, traumatic. As Jeremy Holmes (1993) notes: "Attachment theory is in essence a spatial theory: when I am close to my loved one I feel good, when I am far away I am anxious, sad or lonely," (p.67). Holmes also describes a naturalistic study of mothers and their toddlers in a London park made by Anderson (1972): The mothers sat on the park benches, reading or chatting while their children toddled or played on the surrounding grass. He found that each child had an invisible radius- a Maginot line - beyond which it would not venture to go. When it neared the limit it would begin to look anxiously toward the mother. Attachment exerted an invisible but powerful pull on the child.

   Finally, attachment researchers have recently described a most disturbed category of insecurely attached children: they call them insecure and disoriented. When such a one-year old child is reunited with its parent after Mary Ainsworth's naturalistic "Strange Situation" test, he may typically go toward the parent, then go away, spin around, bang his head on the wall, kick the floor. Instead of comfort, the return of the parent leads to a state of disorganization in the child. The researchers have found this kind of behavior in the presence of abusive, frightening, and disorienting parental behavior. Remember this in a little while when I show you a video of six-week old infants that I began twenty-five years ago to describe as being in cephalic shock. For purposes of today's theme, one could say that the disoriented one-year-olds are showing us a chaotic mix of fight, flight, and proximity-seeking behavior.

B. How relevant is an ethologically derived model for human infants who sustain trauma during their prolonged state of biological helplessness?

   I. This prolonged helplessness is fairly universally agreed upon by a broad range of disciplines to uniquely distinguish us from our animal brothers and sisters. Evolutionary biologists

explain that our relatively huge brains had to get through the floor of the pelvis before we are even close to ripe. Winnicott (1940) himself poetically captured the reality of this helplessness by saying: “There is no such thing as an infant “…he then explained that “whenever one finds an infant one finds maternal care, and without maternal care there would be no infant” (n.a.).

The human infant at birth and for months afterward is both enormously helpless and amazingly resourceful and prepared to encounter the world around it. However I still urge caution as we compare Peter Levine's immobile antelope and the stunned six-week old infant you will see in the video. To the extent that it is able, one can see this infant protesting its poorly attuned care. One can even interpret its movements as expressing fight/flight. One sees the infant's repeated Moro or startle reflex easily enough, and one sees it becoming overwhelmed, glassy-eyed and limp. It is reasonable to describe it as going into a freezing/numbing response. Its orienting response, not yet neuroanatomically mature is clearly overwhelmed, but then, dear God, the danger is coming directly from its haven of safety.

II. Here then, is what I called cephalic shock in 1975 (Lewis, 1981). It is at the interface of developmental and shock trauma. We begin to understand that something very specific happens when the human infant is assaulted by its caretaker, soon to become its primary attachment figure. How are we to relate Peter Levine's adaptive, instinctual fight/flight responses to an infant that can neither flee nor fight? This infant will not be able to crawl away from or crawl towards its caretaker until he is at least seven months old. His scream, his cry of distress is the biological signal by which he maintains proximity to an attuned caregiver.

III. *(Five-minute Brody-Axalrad video)* These mothers are not attuned; they are out of touch. They are trying to feed their babies, not harm them. What is terrible about these feedings is that the babies' signals of distress do not bring them relief, but only increase their abusive handling. When does unattuned handling become abusive and when does it make sense to call someone a perpetrator? Many of my adult patients, still in cephalic shock, have not been able to make sense of all this. And many of these adults may have to scream and express profound terror, rage and anguish - this was their primary survival response available as infants- this was their fight - a protest from their pulsing core. With such a full-throated, rhythmic cry, a baby is both organizing its bodily self and the care-giving world around it. But these mothers could no more tolerate or respond empathically to such a rhythmic cry than they could to the rhythmic sucking and cooing of their infants. So if “catharsis” is the dirty word for the core protest that these patients need to express in therapy, I would drop the word and allow them the experience of being attuned to, as they recapture their life rhythm, their embryonic inner movement.

A big concern that I have about this morning's presentation:

1. The points of view from which Peter and I view similar phenomena are so difference, or
2. …the phenomena, per se, are so different that…
3. …we will miss each other and not have much of a dialogue. Hopefully, if this does happen, it will be remedied during the panel discussion afterward.

About two years ago, Maryanna Eckberg and I struggled to understand what shock trauma had to do with the developmental or character-based trauma that many of us in bioenergetics grew up with. we had many more questions than answers. I find the term "shock trauma" perhaps necessary but unfortunate because…

1. …it is redundant: trauma, by definition, is overwhelming or shocking, so we are actually left with "shock shock".
2. …every shock to an organism occurs at a particular point in its development, its life cycle.

Its impact depends to a great extent on whether it occurs in the dawn, the noon or the twilight of a person's life. Mainstream definitions, probably too simply, describe trauma as either acute or chronic.

RESILIANCE AND VULNERABILITY TO PTSD

But what is it that enables some fortunate people to trust their basic bodily instincts and intuitively zigzag away from an ongoing automobile? Such people do not panic or freeze when fight or flight is still possible. In my opinion many people who turn to a body-oriented therapy for healing sense that they have largely lost this basic bodily trust. I tend to describe many of them as being in cephalic shock. Peter Levine suggests that the path back to this innate somatic resourcefulness is via our "felt sense". He says that in so facing our traumas we arrive at the immediacy of our animal natures' wisdom and innocence.

I suggest that, while this may be true, the best chance for such wisdom and innocence is to be lucky enough the first time around to have caretakers that are empathically and effectively attuned to us. Nowadays we call this being a securely attached infant. Such infants are securely attached both to their parents and to their psyche-somas. Recent research (Shore, 1996) is documenting how the experience of being attuned to in infancy hard-wires the basic bodily trust into the nervous system, into neurobiological patterns of coping with stress. We used to say the infant internalized the attuned care as an ability to regulate and soothe itself; it treats itself the way it was treated. We are beginning to be able to measure the neurochemistry of how this gets built into babies by their experience. Their levels of cortisol, for instance, and the balance of their sympathetic and parasympathetic nervous systems reflect their ability to modulate their energy and feelings and to recover smoothly from adversity. The babies in the video internalized a chaotic experience many times a day. Unfortunately each traumatic feeding is likely to have made them less able to cope with the next. This is how their daily developmental trauma makes them more vulnerable to the next "shock" trauma that life has in store for them.

Cortisol normally turns off our body's reaction to stress once the stress is past. This stops us from developing PTSD. So Denis Charney and Rachel Yehuda and others are exploring the hypothesis that people are vulnerable to develop PTSD when the cortisol levels in their blood are too low at the time of their trauma to contain their body's biologic reactions. And indeed in a group of motor vehicle accident victims, blood drawn within an hour of the accident, showed significantly lower cortisol levels in the subgroup who developed PTSD six months later. Similarly, women with a risk factor of prior rape also had lower cortisol levels. And finally on a more "developmental" note, a number of studies of the children of holocaust survivors showed them to be both low in cortisol and far more likely to develop PTSD in response to their own response to adverse events. The risk factor in the child is PTSD in the parent, not the holocaust per se. So, although it is politically incorrect, this research suggests that what makes an event traumatic, is who you were before it struck...in addition, of course, to how the environment has responded.

{V} TRAUMA, RESILIANCE AND RELATIONSHIP

(I) ATTUNED RELATIONSHIP: Somehow, trauma is leading me closer and closer to the therapeutic relationship, although I think that is Bob Hilton's and Martha Stark's assignment. How can you stay away from relationship if you believe that lack of attunement is not only traumatic per se, but that it leaves you more vulnerable to future bad things. Now I have been saying that the ability to regulate our level of feeling and/or to soothe ourselves when distressed are not hard-wired into us at birth. They are not, in other words, inherited givens built into our primitive survival systems like the orienting and fight/flight reactions on which Peter Levine focuses. Consequently they will not automatically come into existence when the chronic hyper-arousal of trapped traumatic energy is therapeutically released. Rather, in the same way that emotional self-regulation is slowly internalized over the first two years of life from countless interactions with attuned caregivers, it is slowly internalized from therapist to patient.

I believe, for instance, that Peter Levine, in the process of skillfully helping his patient to therapeutically release the trapped traumatic energy, is also doing something else...something crucial. He is being an attuned caregiver! How, you may ask? By titrating, with great sensitivity, how much arousal, how much pain, how much pleasure his patient can optimally tolerate. In the examples he gives us, Peter may tell us that he is a guide, that the patient is doing his own healing. But it is nonetheless Peter's exquisite attunement to his patient's felt sense which models for the patient a self-attunement and which guides him through the shoals of re-traumatization and lands him on the secure shore of a better life.

Now, as I have already said, I do not believe Peter would have this outcome with every trauma patient. I think our approaches are a deep expression of who we are and they work with some patients because of who they are. I have been touched to see how Maryanna integrated Peter's insights into who she was. His work inspires me, and yet I will resist the temptation to over-idealize Somatic Experiencing as the answer, the new system-into which my patients must fit themselves, and which, in any event, I will never do as well as its inventor. In case you do not get this, let me illustrate by getting personal:

(II) PERSONAL EXAMPLE: I remember only too well how, as a Bioenergetic patient, I surrendered my body to Bioenergetic therapy and was envious of my therapist's interest in and relationship to its (my body's) vibration, and responses. I sensed this envy deep within myself (although I did not realize what it was at the time) as I bent and stretched in various positions which were intended to open my body's pulsatory, spontaneous motility. I felt that my therapist was more interested in my spontaneous motility than in my inner experience of myself. I believe that this was an accurate perception on my part because, as a Reichian at heart, my therapist was trying to open the underlying biopathy that was fueling my neurosis.

So, if I consider the parallel to this in Levine's model of blocked adaptive and orienting responses to trauma- locked in the nervous system- and fueling the many symptoms of PTSD…were I, Bob Lewis, the patient experiencing "Somatic Experiencing" (Levine 1997), might I not, once again, watch with envy and languish from that place deep within myself…envy at my therapist's fascination with my 'felt sense' and 'micromovements'? Now Peter Levine might point out that Somatic Experiencing does not heal all ills, and that my deeply withdrawn self is not a casualty of the kind of trauma his work addresses.

Or, he could clarify that his and my deep attentiveness to my felt sense and frozen life movements (emergent 'micromovements') would not lead me down the path of my earlier Bioenergetic therapy. This time my felt sense would lead me to truly release the deep shock in my structure such that my deeply dissociated, secret self could finally find a secure place in this world.

But then I would have to clarify to Peter that my trauma was so essentially a betrayal by those that I loved and trusted that there is simply no technique on this planet that overrides what I sense about my therapist's humanity…his ability to tolerate my hatred and brokenness…his ability to be with me in our mutual helplessness. I need to know if he is able to spend as much time with me- not knowing if we will make it- as he spends with the therapeutic approach that makes him comfortable.

(III) BETRAYAL: What is so special about betrayal? Betrayal is the violation of implicit or explicit trust. It is by definition an interpersonal experience (Gartner, 1999). Now the betrayal that Levine deals with in his writings is, as I understand it, largely focused on a large, societal level, and then more specifically on ignorance/insensitivity of the medical/dental professions in subjecting their patients to a variety of procedures with little awareness of their power to traumatize. We rightfully expect more of those trained to help us when we are ill or injured. I have already mentioned that this has been important information for me personally.

What also needs our attention here, is the much more personal betrayal, the betrayal of our faith in intimacy which results when our primary attachment figures are the ones who are the perpetrators. You saw examples of this in the video, where the mothers had no conscious intent to harm their babies. Indeed, a great deal of abuse of children is done by parents who are too out of touch/in denial to realize what they are doing. But the big question I am raising is how helpful the ethological frame of reference of Somatic Experiencing is for the actual patients that many of us see. This betrayal happens to patients who are

conceived and reared in chaotic, neglectful and violent environments. In such families of origin, their daily bread, so to speak, consists of physical abuse, sexual abuse, spousal abuse, substance abuse, and extreme neglect, which leaves these children unattended and therefore additionally at high risk for accidents and further abuse from predators outside of their families. In such settings shock and developmental trauma are organically entwined. Any specific outrage may be embedded in a chronic, daily environment where caretakers do unspeakable things in a random or unpredictable, or predictably sadistic or chaotic manner.

So what happens to us when the survival instincts that are genetically programmed into our bodies impel us ever closer to the source of danger? It may sound strange to you, but think about it: our body's natural response is not adequate for such an unnatural situation. In a sense, our body betrays us, just as our body may become sexually aroused during an incestuous episode that at the same time feels disgusting to us. I do not know how often animal caregivers traumatize their offspring, but clearly not often enough or for enough time for us humans to have inherited a healthy biological response to human perversity. It is this crucial issue I had in mind when I expressed concern that Peter Levine and I might come from such different perspectives that there would be no dialogue. Let me quote him (Levine, 1997) on what I believe is the very same issue:

> Unlike wild animals, when threatened we humans have never found it easy to resolve the dilemma of whether to fight or flee…however the genetic memory of being easy prey has persisted in our brains and nervous systems…our human brains often second guess our ability to take life preserving action…Animals like the agile, darting impala know they are prey and are intimate with their survival resources. They sense what they need to do and they do it…the line is not so clearly delineated for the human animal…our rational brains become confused and override our instinctive impulses, (p. 18).

It is not what Peter Levine calls the human rational brain, but the deepest survival instincts which throw the ten-week, ten-month, or ten-year old human animal into shock when its primary care-giver abuses it. Peter Levine speaks of our “rational brains” becoming confused and interfering with our intuitive responses. Now I agree that most survivors of childhood incestuous sexual abuse are indeed deeply confused by their shame, by their loss of control over their body's responses, and by the treachery of their loved ones. But the confusion is also and primarily on a much deeper level, a cellular level. Like an amoeba our organism recoils and contracts from pain, but simultaneously, like a mammal its protest and expansion are genetically coded to bring it closer to the source of pain (remember the confused, contradictory behaviors of the disorganized one-year olds in the Strange Situation). Attachment behavior increases at times of danger…for an infant, a poorly attuned caregiver equals danger. So, as I describe cephalic shock, once the infant is capable of thinking about an experience that makes no sense, his rational brain (cerebral cortex) becomes confused and he goes to the psychoanalyst, but finally it is his brain stem, thalamic, midbrain and limbic confusion that brings him to us...the body people!

(IV) FIRST VIGNETTE: I am thinking of Charles, a man whom I worked with whose neuromuscular system was locked in this kind of somatic terror and confusion. His core body feeling about his bond with his mother was that her touch felt like that of the water leeches that suck your blood. But leeches need your blood to live, so if he moved, she would die...and as noxious as she was to him, she was also his life

source. So he froze...his spastic muscles, rather than his skin, became his containing membrane. As he put it, " You need a mother to learn how to use your muscles properly." As an adult he moved mechanically and without pleasure and felt that he had been able to organize a false neuromuscular self with his left-brain. In a poignant attempt to hold himself he had substituted his musculature, a part of himself, for the too dangerous significant other. He had done the same thing with his mind, literally splitting his thought process into a speaker and a listener. It was not easy to change this in therapy because beneath his control lay chaos. He sensed his flexor and extensor muscles contracting simultaneously instead of alternately; and beneath this paralysis, was the fear that he would go out of control, move violently in opposite directions and, in so doing, tear himself apart or destroy others. Charles slowly learned in our therapy how to reorganize himself in his body by internalizing how he could bodily be with me- that is, how he could touch, move and breathe with me. He learned, for instance, that he could move for himself and still be in contact with me. This vignette actually supports the Talmudic message that "life is with people", because Charles' path to a vital connection with his core bodily self was via a somatic intimacy with me.

(V) SECOND VIGNETTE: In my second and last vignette, my patient Emily, like Charles, also presents with chaotic, bodily states/memories that cannot be integrated. In addition, however, since her story is about incestuous sexual abuse, it includes intolerable feelings of shame, contamination and heartbreak. As you will see, there was nothing smooth about this therapy; rather, struggle and unpredictability seemed organic to it. Emily, a woman in her forties, functioned competently, but I thought well below her potential. Whatever she accomplished was accompanied by her pervasive self-denigration and loathing. She had a deep sense of herself as contaminated and therefore toxic to others. Her outward manner was accommodating and sweet to the point of apologizing even when others were in the wrong. Emily was never that far from sudden episodes of cold withdrawn hatred, which she experienced as a sheet of deadness coming over her, and which could last from moments to months at a time. Emily had a deep conviction that her hatred and contempt would destroy any man she got close to. I was no exception. One moment she was a femme fatale and I was a startled therapist. The next moment she would become terrified of me and I would still be a startled therapist. The next moment she would desperately plead with me to tell her if she was too much for me, too hard for me. Would I just come out and tell her, she implored me, if I did not like working with her? So what do you think I did... I lied...or I did not tell the whole truth. She really was not easy for me. In fact, she sort of drove me crazy. So did my mother. But now I was the therapist, so I split off a little bit and told Emily that while she was not the easiest patient I had ever worked with, she was not a problem for me.

But Emily was not stupid. She told me recently that the most important factor in my having been able to help her was that I stayed with her- that I did not give up on her even though she sensed all too clearly that she pushed me close to my limits when she did what she had to do in our sessions. She made me feel small, helpless and frightened, and my therapeutic sermons were thinly veiled attempts to plead with/bully her into becoming a more cooperative patient. But there was somehow more love than hate, so Emily and I are still here. This is what I meant earlier when I spoke about my own betrayal experience and the

consequent core importance of a relationship I could trust. Emily had also been betrayed as a child, and now she needed to know if I would stand by her even when her sessions left me feeling hateful and helpless...feelings she had been alone with for many years.

To our great amazement, Emily began about two years ago, to go into episodes akin to what Janet and van der Kolk and others have described as their patients' way of "remembering" something that has happened to them. These "flashbacks" lasted between ten and thirty minutes, during which she would be flooded with panic and dread, scream "no" repeatedly, and twist and writhe and emit anguished sounds as one would who was being overwhelmed by an implacable, vastly superior force. No two episodes were the same, but they all had this overall character. Frequent additional features included her having difficulty breathing, and also gagging and choking and attempting to brush something away from her face. Typically, after the episode, Emily might report that she had tasted semen in her mouth, and felt an incredibly intense "buzz" in her entire body, and a heat or excitation in her pelvis that was way beyond anything she could tolerate - as she put it: "I'd go mad if I couldn't turn it off". At times she would come out of the episode struggling to find language to express how unspeakably humiliated and defiled she felt.

Often during the episodes Emily clung to me desperately. Afterward she would tell me how crucial it was to her that our thoraces were held tightly together as she twisted and writhed around on the ground. In some ways I found this somatic remembering part of Emily's work as frustrating as the earlier emotional encounters with her. When she was seducing me or hating me, I may have felt helpless, but at least I felt involved. However during the flashbacks, in spite of the intense physical contact, I felt somewhat like an observer of an outrage in which I was helpless to intervene. Emily herself was maddened by a lack of images and/or any actual memory of what this was all about. Over the course of a year, meeting approximately once a week, our progress was slow. if, at times, she seemed closer to being able to see/know what had happened, she moaned despairingly, "I will lose everything".

This was our basic dilemma: were we re-traumatizing Emily by deepening the grooves of her neuronal and neuro-chemical activation patterns? Were we mired in a transference / counter-transference reenactment in which Emily was bonded with me as both the persecutor and the provider of nourishment? I was not sure, but I hoped not. On the other hand, you cannot integrate state-dependent memories that you do not have access to. So I hoped that we were accomplishing something along the lines of exposure and desensitization of an overwhelming experience. Emily felt very strongly that she needed more contact with the Emily-in-the-episode, which had been lost to her all these years. She also felt that while she was in part overwhelmed during the episodes, she was also very much in the room in present time with me as her safe anchorage.

But, let me ask you, why was I neither able a) to help Emily to slow down and modulate the degree of overwhelm she felt during the flashbacks nor b) able to help Emily to better integrate what she seemed to want so deeply to come to terms with? Which of the following three explanations is the best?

1. Because I am not doing the therapy properly?

2. Because Emily gets access to her state-dependent memories, that is to say, her lower brain centers are entrained, in an all-or-none fashion that very probably has genetically wired, species-survival value?
3. Because, as Blaise Pascal said in 1670, "The heart has it's reasons, that reason knows nothing of"?

I feel that all three explanations are excellent. Emily herself leans towards Pascal. That is why she said:

"If I see/know what happened, I will lose everything." Emily is telling us that the active betrayal of trust of her beloved father in his sexual abuse of her-and the passive betrayal of her non-seeing, neglectful mother-this betrayal and the resultant loss of herself and her world are the overwhelming traumas that she cannot face. Intellectually Emily can infer from numerous details of her life that her father was the perpetrator but, as she puts it, "I can't believe what I sort of know". So it just may be that no matter what therapeutic approach we use, Emily will decide in the wisdom of her being how quickly and how much heart-breaking, crazy-making betrayal she can face. It is this type of critical issue that requires a more complex model for human animals than for their less perverse brothers. We humans can use language to deceive our children and we are vulnerable to being shamed about our bodies and sexuality.

Emily, you will remember, had walked through her life feeling bad and contaminated. During her episodes, Emily usually experienced her limbs, particularly her arms as impotent: they often moved, as she put it, "ineffectively and purposelessly". A few months ago, while she was still partly in her flashback episode, I suggested that Emily take hold of my forearms with her hands and hold them firmly. She did so for about a minute, appearing extremely frightened initially, less so as the seconds went by. Her comment after the session was "it was good that you hung in and gave me directions...to know that I have a brain and can make movements and could see your eyes."

Over the next few sessions, it became clear that my intervention had triggered an implicit body memory. Her hands became totally numb, then very slowly formed into the shape of a "c". With my encouragement she looked at her hands and the tactile and kinesthetic memories slowly formed an "intention". Emily said, "I feel I must have touched, fondled someone's genitals." She continued:

> "I knew I had to make myself up, I mean become someone else - I died. I still can't see a picture, but this time it is different. I know what happened...I'm sorry, I'm sorry, I'm sorry. No wonder I always felt so guilty...I can almost hear my dad saying 'nothing happened - we'll just act like everything is o.k.'"

So, for the first time, Emily consciously encodes in words a crucial part of the abuse at the hands of her father--but in this instance involving her own hands. This seems crucial in freeing her from an unconscious, sub-cortical confusion as to who the real perpetrator was. She now has a memory- part of a linguistic narrative from a time and place in her life. Emily is still in therapy with me. Her life has gotten quite good, and as she still wants to explore what happened, she still goes into her episodes, each time now getting a little closer to seeing the dreaded and elusive picture and being able to feel the depth of the heartbreaking betrayal of her love for her father.

SUMMARY AND VISION STATEMENT:

I believe that if you cannot get it right the first time by choosing caretakers that are effectively and empathically attuned to you, you may be fortunate enough to find a body-oriented therapist that will over some time restore you to a precious measure of oneness with your animal nature. But, **you will still be a wounded human being in recovery**. I have never met, for instance, any healers who were not still wounded human beings.

So, in the spirit of the struggles and questions I have shared, I would like to hear more about Peter Levine's struggles; how, for instance, his counter-transference interferes at times with the effectiveness of his intuitive interventions. The seamlessness of Peter's presentations makes them admirable, but, at the same time, hard for me to relate to. And if I am told that my problem is that my cortex is getting in the way of my inner, primal animal- my intuitive innocence and wisdom- my reaction is A) this is totally true B) once again - **an ideal state is being held up to us as attainable -** in my first life it was the wisdom of the body and the genital character.

So I would like to believe that I am a somewhat life positive person and that when I meet my first therapist ever who proves to be a spontaneous, joyful and wise human being, I will better grasp the transformational message of Somatic Experiencing. We may indeed be able to transcend the scars of trauma, like the tree that, struck and bent by lightning, recovers to reach anew towards the sunlight. The story of the tree is deeply appealing: the analogy inspires us not to give up even when we are broken by life. But, once again, let us not take our interspecies analogies too literally. Trees, as distinct from people, most likely do not feel guilty about their sexual responses, and most definitely must grow towards light in order to produce food via photosynthesis. And we humans rarely ever fully overcome the vulnerability of our wounds. I believe it is rather in the acceptance that we've been broken by a force greater than us that we gain the wisdom of which Aeschylus speaks:

> Even in our sleep
> Pain which cannot forget
> Falls drop by drop upon the heart
> Until in our own despair,
> Against our will,
> Comes wisdom
> Through the awful grace of God.

BIBLIOGRAPHY

1. Aeschylus. (approx. 450's,460's B.C.) Oresteia: *Agamemnon*, l.177.
2. Anderson, J. (1972). Attachment out of Doors, in N. Blurton-Jones, ed., *Ethological Studies of Child Behavior*, Cambridge, Cambridge University Press.
3. Brody/Axelrad.(1967). Video: Forms of Feeding at Six Weeks. *Mother-Infant Interaction.* University of Calif.
4. Extension Center for Media , Berkeley, CA 94720.
5. Gartner, R.B. (1999). *Betrayed as Boys,* Guilford Press, New York, 13.
6. Holmes, Jeremy. (1993). *John Bowlby and Attachment Theory,* Routledge, London, 67.
7. Levine, Peter A. (1997) *Waking the Tiger*. North Atlantic Books, Berkeley, 18.
8. Lewis, Robert A. (1981). The Psychosomatic Basis of Premature Ego-Development. *Comprehensive Psychotherapy*, Vol. 3, Gordon and Breach, New York.
9. Pascal, Blaise. (1670). *Pensees*. Lafuma. L.(ed.). (1960). Paris: Delmas.
10. Resnick, Helen. (1993, August). A Model for Working With Shock Trauma: An Ethological and Bioenergetic Approach. *Pacific Northwest Bioenergetic Conf. Treaining Days Journal,* Barbara Miller, ed.).
11. Shore, Allen N. (1996)The Experience-Dependent Maturation of a Regulatory System in the Orbital Prefrontal Cortex and the Origin of Developmental Psychopathology". *Deveopment and Psychopathology,* 8, Cambridge University Press, 59-87.
12. Winnicott, D. W. (1940). Discussion at a Scientific Meeting of the British Psychoanalytical Society.

