

The Logic of Bodywork for Dissociation and Traumatic Stress

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From birth, our body is our link from ourselves to our world. It is the key to our knowing who we are and what we need. The detachment from our bodies that occurs during trauma leaves us without this critical information. Wilhelm Reich, a protégé of Sigmund Freud, was the first westerner to study the impact of trauma on the body. As early as the beginning of last century, he strongly asserted that child abuse frequently causes neurosis and that the key to unraveling the neurotic behavior, is the body.

In Character Analysis (1945), Reich describes how talk therapies, by themselves, are insufficient to address the body's defenses. He wrote that "through working with the body, the remembrances of traumatic mistreatment of every kind, love frustrations and disappointments with parental figures reappear". Reich stressed the need for freeing emotions and memories stored in the body allowing the client to release self-imposed limitations. Reich discovered that he could affect this release and heal traumatic material by using physical techniques such as manipulation of the body, pressure points, touch and breath-work in addition to traditional psychoanalysis.

Reich insisted that people experiencing repeated emotional and physical traumas build a kind of armor, or dissociative wall, in their bodies, which protects them against the experience of trauma. Focused muscle tension and dissociative walls help the developing child avoid painful emotions. The armor persists into adulthood, leaving the person in the throes of its unconscious battle. The embedded tension and the ongoing experience of anxiety restrict an individual's capacity for pleasure. For many, this means the development of serious mental illness. At best it constricts the person's ability to fully experience life and participate in relationships. This is clearly evidenced by the abundant literature detailing

the debilitating effects of trauma on the nervous system, and the emotional states of survivors.

Dissociation occurs because trauma is experienced as overwhelming and incongruent with the survivor's view of self and the world. For children it is insurmountable. They cannot survive and integrate their worldview with what is taking place. But the child must survive. In order for that to happen, the normal flight or fight response is, of necessity, stymied. The only choice the child has is to remain physically present, but to energetically leave the scene. The child withdraws awareness from the parts of the body that are hurt while the muscles retain the impulses to protect. This dissociation from the body, therefore, becomes the basis for the somatic symptoms that cause their severe distress and dysfunction. (Fraser, McKenzie & Showell, 1998)

It is well documented that, in trauma survivors, the Central Nervous System (CNS) develops conditioned emotional responses to any stimuli reminiscent of the original traumatic event. The brain is wired to recognize any sight, sound, smell or even body sensation that may be associated with a traumatic event with a "trigger" response, putting the individual on hyper alert to avoid possible re-exposure. Clearly, the neuro-biological traces of trauma impair quality of life and lead to severe symptoms that are not clearly understood. The symptoms of traumatic stress are expressed on many different levels and include intrusive re-experiencing, dissociation, learning difficulties, numbing, amnesic states, and aggression against self and others (van der Kolk, van der Hart & Burbridge 1995). Some people experience "flashbacks" to the original trauma continually.

Under normal conditions, the autonomic arousal function, of course, alerts an organism to potential danger. Yet for survivors of many types of trauma, this persistent autonomic arousal to trauma related stimuli is present continually. This constant bombardment drives individuals to dissociate, yet again, from the external or internal "triggers." The result is that they must further remove conscious awareness from the sensations, events and emotions associated with the triggers in order to tolerate this insistent pressure. Continually deprived of their body sensations to alert them to impending threat, they cannot take appropriate action to protect themselves. (van der Kolk, van der Hart, Burbridge, 1995) Nor can they make sense of what is happening to them. This leaves them confronting their environment with emotional constriction and withdrawal from their cognitive and physical awareness. Their bodies react

to their own particular set of physical and emotional stimuli as if there were a continued threat of annihilation. The somatic representations of their traumatic experience continue to plague them with no cognitive awareness of the cause of this distress.

Those traumatized during early childhood have little insight into how these current emotional states of anxiety, impulsivity, anger, and social fear link to that past emotional distress (Perry, 1999). For example a woman whose family disclosed to her as an adult that a neighbor had repeatedly raped her when she was a child held no cognitive “memories” of the abuse. Yet she carried many of the neuro-biological symptoms listed above. Indeed in many cases, the individual is completely unaware of ‘why’ they feel so fearful, depressed, panicked, anxious, distrustful, or rageful.

Body psychotherapy is now being recognized for its ability to impact these somatic symptoms. In 1992, McLennan’s study hypothesized that somatic interventions could reduce the somatic symptoms of trauma as well as increase body awareness and self-concept. He showed that the survivor could gain internal control and reclaim or re-associate, the body. The clinical trials resulted in evidence that symptoms of shock and post-traumatic stress are reduced with bodywork. They were able to relieve anxiety, improve self-concept and empower survivors to reclaim their bodies. (McLennan, 1992)

With the expanding use of mind-body therapies over the past two decades, a number of therapeutic tools have been developed which appear to decode, or perceptually reframe, traumatically encoded cellular memory paradigms. Various mind-body techniques are showing immense promise in helping to integrate traumatic material. Bio-feedback, somatic therapy, Bioenergetics, Hakomi, and Radix work directly with breath and simple body awareness (among other techniques) to assist healing. In my own work, clients have re-associated parts of their bodies and dissociative systems through working with breath and connecting with pain long held in their bodies. This occurs in spite of their tremendous terror of reconnecting with the pain of their childhood tortures. With the compassionate presence of a body psychotherapist, clients can begin to face the secrets held in their bodies through working with their body.

In *The Invisible Wound* (1993), Wayne Kritsberg asserts:

...an experienced therapist (who is knowledgeable about the inter-relatedness of the body, mind, and emotions) can be of great assistance. If your emotional memories are repressed, or if you have no cognitive recall of the abuse, such a therapist can help you reclaim your past by focusing on your present experience, especially if there is tension in your body. Often these tense areas are physical patterns, which developed to hold the pain of sexual abuse, and focusing your attention on them can release your emotional and cognitive memories. (p. 93)

One factor complicating work with trauma survivors is that we don't have clear understanding of how memory works. Even members of the American Psychological Association agree that mechanisms for memory development "are not well understood" in children who have been sexually abused (APA, 1994). But we do know that children under three years old tend to have less verbal memory of their experiences. (Terr, 1988) This is often the case with adults who have "child alters" or state-elicited distress. As is frequently seen in working with dissociative disorders, symptoms are often not associated with a clear cognitive memory, nor are the presentation symptoms proximal in time to the trauma. In cases like these it is frequently arduous to make the connections which allow for effective talk-therapy interventions (Perry, 1999). Many 'states' of distress are activated without any clear cognitive or narrative associations to a specific trauma or experience, which leads to confusing, and often frustrating attempts to discover what is wrong when the client is in the midst of a severe panic attack or is suicidally depressed.

As therapists we have to use the tools which are at our disposal such as hypnotherapy, intra-psychic interventions, group therapy, and the other traditional approaches. Yet these traditional psychotherapies remain a verbal domain where talking and expressing are critical elements of progress. Communications with children, or with a child ego state, are primarily non-verbal. This is particularly true when communicating about a traumatic event. (Perry, 1999) Traumatized individuals go immediately from stimulus to response without being able to talk about or even figure out what makes them so upset. (van

der Kolk, van der Hart & Burbridge 1995)

What we know about the brain is that while in the middle of life threatening experiences - situations where traumatic events occur - this “problem-solving” knowledge in the cortex is not easily accessed. In the same manner that particulars learned in song, rhyme, or rap are more easily recalled when in a state of high arousal, memory of trauma are more easily recalled in that highly aroused state. This is due to this information being stored in a different form than traditional verbal cognitive information (Perry, 1999). This state dependant memory is critical to understanding how bodywork activates traumatic material that had not been previously recalled.

This lack of cognitive awareness is the basis of dissociation. Dissociative and traumatized clients generally complain of feeling “crazy” and having no intellectual understanding of the body responses that are often terrifying and debilitating. The need then, is to translate these non-verbal elements of the language of trauma into information to be dealt with in therapy. Through bodywork, the state and affect memories can be addressed without the need for an initial cognitive awareness of the traumatic material. Working with trauma on a body level bridges the gap between verbal interventions and the body’s non-verbal processes (McClasky, 1998).

Forms of bodywork are particularly helpful for traumatic response patterns specifically because of the nonverbal nature of symptoms. Though in its infancy, the scientific understanding of the mind-body complex clearly indicates that the neurochemistry of emotion plays a part in lasting successful therapeutic intervention. Mind-body procedures may be most effective in management of Post Traumatic Stress Disorders, (McClaskey, 1998) in part by directly impacting neurochemistry.

In the same way that certain motor activities, like learning to ride a bicycle or play a piano program autonomic motor responses, repeated emotional stress encodes programmed Central Nervous System responses. Also known as “Implicit” memories, these response patterns bypass language and involve automatic procedural and internal states. Using bodywork to bridge the experience into a conscious memory, the client becomes able to make sense of the remembered event, emotion, or sensation. Without

this bridging, the memory will remain an unconscious threat to their mental and emotional state. (Rothschild, 2000)

To begin building that bridge, in the process of body psychotherapy, the survivor activates motor movement. The feeling states containing the implicit memory are then revived. In like manner, the motor (vestibular) movements on a roller coaster can elicit a state internally associated with the playfulness of a small child being tossed in the air by a parent. This is the same manner in which the fetal position brings a sense of soothing and calm. Why? Because during the calmest, safest, warmest and least threatening time in the history of a person's "brainstem", the neuronal patterns associated with the fetal position were then associated with the neuronal patterns of this calm, warm, safe - most soothed position. Accordingly, as a motor or implicit memory occurs when the child or adult moves into a fetal position, the neuronal patterns evoked will induce similar elements of that original, soothed state. People who are feeling overwhelmed, sick, or racked with pain do not usually lie on their backs in the 'spread eagle' position. (Perry, 1999) Through body movement the neuronal patterns associated with the trauma often evoke these implicit memories along with the feelings attached to them.

The breath is the first line of defense the body has against overwhelming feeling; therefore breath is a fluid barometer of body states. Even the simplest forms of bodywork begin with use of the breath. Bodyworkers can easily observe respiration and bring it into the client's awareness. As it is experienced in the body, awareness is one of the most effective tools of guiding people toward reclaiming their physical experiences. By asking the client to close their eyes and focus on their breathing they are redirecting awareness into the body. When limitations occur in a person's breathing cycle, they are unconsciously controlling their body awareness. Breath changes dynamically with any change of body experience. To begin connecting with the body, attention must be focused on the sensations of tension. Behavioral, cognitive and emotional habits can be significantly altered by allowing the client to become aware of how breath effects their emotional state, (Fraser, McKenzie & Showell, 1998) thus creating movement away from the retained patterns of traumatic responses to the present experience. Stress points will tend to relax as the musculature reorganizes in reply to the current sensory awareness of the present experience. With conscious awareness being present, the body can then develop a more alive and responsive attitude. (van der Giessen, 1999)

Psychotherapies that include bodywork are particularly helpful for traumatic response patterns simply because they reorganize experiences in the body. Touch focuses on developing sensory awareness in the body and is frequently being recognized as useful in breaking down traumatic stress responses. This is achieved by first introducing new sensory information, then attaching the soothing and supports that initiate the healing and integration missing in the original traumatic event. The felt presence of the concerned helper and the sensory experience of touch create fresh possibilities for experience as it relaxes the hold of trauma on the body and the spirit. (Fraser, McKenzie & Showell, 1998)

Touch is traditionally avoided in psychotherapy due to the risks of regression, transference and sexuality issues. In bodywork, touch is vital to assisting the traumatized client in developing physical boundaries and body awareness. (Fraser, McKenzie & Showell, 1998) Touch is necessary for the survival of all living organisms, and for the well being of humans. The tactile system is so important that it is the earliest to develop in all animals. The necessity of bodily contact, similar to oral needs, appears to become intensified during the experience of stress. While oral longings may be readily satisfied alone, with food, tobacco, alcohol - body-contact longings can not be satisfied without engaging in contact with another person. (Montagu, 1971)

Trauma survivors have often had touch used in hurtful ways, causing them to shy from touch and resulting in many being touch deprived. Every touch experienced carries a different electrochemical message to the brain. Even small, very light touches can create tremendous brain activity. Accordingly, when someone is touched, it has a big impact on the brain. When that is expanded to hugging, the response is magnified many times because it brings with it those implicit memories of previous experiences and the attached emotional meaning. (Welch, 1988) As an effective and powerful tool, touch activates cellular memory and reprograms it with new meaning in the survivor's present reality. When a person is suffering and stressed, taking their hand usually produces a soothing effect, reducing anxiety, and generating a feeling of greater security. (Montagu, 1971) For trauma clients, touch has generally been abusive, invasive or absent. Significant healing of these wounds can take place when nurturing, non-invasive touch is provided during body psychotherapy. (Fraser, McKenzie & Showell, 1998) The outcome of the work is a radical change in the survivor's contextual understanding of the meaning of touch.

During an interview following the September 11 attack on the World Trade Center, Bessel van der Kolk (Korn, 2001) emphasized that the natural human instinct to comfort traumatized individuals is what is needed to restore an individual's missing sense of safety. He stressed the importance of allowing people time to process, be with each other and, he says emphatically, "most of all, to hug".

Through bodywork a therapist can assist clients in reestablishing their abilities to cope with the traumatic memories. These conditioned reflex mechanisms seem to become decoded at the cellular level thus releasing the stimulus generalization effect on cellular operation. The way this actually takes place is not thoroughly understood, but the theory is that connecting on a body level with the various circumstances of a traumatic event during therapy may revive the stress-released hormonal substances originally encoding that event on the cellular level. The cellular memory can then be brought into contact with ordinary cognitive function allowing the traumatic memory to be therapeutically reframed. (McClaskey, 1998) Through grounding in today's reality by developing a connection with the body via the eyes, hands, feet and legs, the person is kept in the present while integrating the memories and feelings associated with the traumatic experience from the past. (Fraser, McKenzie & Showell, 1998)

So we see that the brain stores traumatic events from the past as cognitive, motor, emotional, and state memories altering the functional capacity of traumatized individuals. (Perry, 1999) Post Traumatic Stress Disorder is a manifestation of these traumatically encoded brain responses. Research now indicates that for therapy to have lasting effect, it is essential that a primary focus of intervention entail isolation and decoding of the traumatic memory pattern. (McClaskey, 1998) Avoidance of these traumatic triggers can lead to significant impairment and recurrence of posttraumatic helplessness states. (van der Kolk, McFarlane & Weisaeth)

Therapeutic exposure, then, is required in order to conquer learned helplessness. The conclusion then is contrary to many current methods for addressing dissociative and traumatic stress symptoms; addressing the recalled events buried in the client's psyche appears to be imperative to long term therapeutic impact. (van der Kolk, McFarlane & Weisaeth)

What we know from clinical experience and from research, is that if the current exposure were consistent with a fear memory, it would be expected to reinforce the fear, re-sensitize the wounding, and increase the chances of developing PTSD. This is the manner in which much early work with dissociative clients was handled, thereby creating the impression that the re-experiencing of trauma was in itself damaging to the client. Clearly, the unrestricted, unstructured “abreactive work” that was done in the early years of Dissociative Disorders treatment was re-traumatizing. Body psychotherapy techniques provide a structured environment, containing the necessary ingredients for integration of traumatic material.

Two conditions appear to be necessary to reduce these severe somatic complaints. (Foa & Kozak, 1985). First, the client's have to attend to fear-relevant data in a manner that activates their memory of the fear. It is clear that if fear is not experienced, the structure of their fear cannot be changed. Secondly, to form a fresh, non-fear structure, some of the particulars that evoked the fear must not be present in this new fear-provoking context. Memories must be integrated into the survivor's present reality as they arise. They have to be aware of who and where they are as the feelings take place for the emotional discharge to have any lasting impact. Only through awareness of the existing time, place, and situation can the bridge to reality form and allow for the feelings to be released. Without this element, people repeatedly regress into childhood memories containing overwhelming feelings and nothing changes (Kelley & Kelley, 1994).

The critical element, therefore, in any treatment, is to expose the survivor to an experience sufficiently similar to an existing traumatic memory in a manner that allows them to remain in touch with their present reality. By doing so, it activates the fear memory, while at the same time containing aspects that are incongruous enough to change the experience and conclusions from the first event. This allows the traumatic event to be integrated into their current experience with a sense of personal control. (Fraser, McKenzie & Showell, 1998)

Through the compassionate presence of the concerned therapist, bodywork can be an effective method of intervention. To be effective, the following three conditions need to occur: 1) they must experience exposure to feared conditions, 2) this must occur in a context of experiencing social bonding, and 3) they must experience some degree of personal control (van der Kolk, McFarlane & Weisaeth). By using

even simple bodywork methods, the client is able to stay present as awareness and boundaries develop, allowing feelings and memories to emerge. Integration of the traumatic experience can then become a conscious, personal event that belongs to the past, resulting in the client obtaining a sense of mastery and personal control. The logic of bodywork then, is in this integration of physical and mental awareness, providing mental health practitioners invaluable assistance in dismantling the devastating effects of Dissociative and Post Traumatic Stress Disorders.

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