

MISERABLE COMFORT

Trauma, Attachment, the Brain, and Pesso Boyden System

Psychomotor Treatment: A Literature Review

Aimee C. Pearson

Trinity College of Graduate Studies

Approval Page

Dedication

This dissertation is dedicated with gratitude to my Abba, you always meet me in the darkest and loneliest places in my life.

To my husband Mark and my son Brennan, you both supported me and believed in my vision, sometimes more than I did.

To my Mom and Dad,
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Abstract

This dissertation examines the following essential issues: (a) The family's ability to emotionally connect and attach to their infant early affects the long-term consequences of trauma, (b) The importance of bonding and attachment and their impacts on the brain's neurochemistry. (c) The failure to integrate a traumatic experience into autobiographical memory develops into PTSD, (d) Chronically traumatic environments create within the child a bonding to unsafe attachments, which left unresolved lead to repetitive self-destructive behaviors, and (e) Pesso Boyden System Psychomotor Therapy (PBSP) is an effective complimentary treatment that helps the client integrate somatic processing with cognitive and emotional processing in the treatment of PTSD.

Introduction

Trauma clients frequently need more than one therapeutic intervention. When one therapeutic approach is unsuccessful, the therapist may need to consider, not whether the client is resisting, but timing, technique, and practice. This allows the therapist to design an approach specific to the needs of the client. This paper describes a technique that can be useful.

The treatment goal is to find a way in which an individual can recover the traumatic memories and integrate them. For this to occur, merely uncovering memories is not enough; they need to be modified and transformed--placed in their proper context and reconstructed into neutral or meaningful narratives. Pesso Boyden System Psychomotor Therapy (PBSP) is a method that integrates the somatic processing with cognitive and emotional processing in the treatment of trauma. The PBSP treatment can be used or adapted within existing models of therapy, expanding and enhancing what is already being done. Traditional psychotherapy addresses the cognitive and emotional elements of trauma, but lacks techniques that work directly with somatic elements. These approaches underestimate how profoundly trauma affects the body and how many symptoms of traumatized individuals are somatically based. It should come as no surprise that some traditional approaches have had limited effectiveness. Pesso argues that treatment of an early significant trauma requires the involvement of the body to rebuild a healthy emotional structure keyed to a traumatic memory (Pesso, 1989). Body psychotherapists who incorporate techniques to help integrate material stored in the body provide a means for expressing somatically entrenched emotions. Pesso compliments traditional and body psychotherapy approaches with his Pesso- Boyden Treatment modality to increase the effectiveness of trauma therapy.

PBSP creates a somatic binding of traumatic memories through a focus on feelings, bodily sensations, symbols and memories. Before practicing PBSP, it is imperative that the clinician understands the different characteristics of trauma and appreciate how trauma creates deeply somatic links to ego and emotional structures. This understanding provides a pivoted key to treating the trauma client.

The PBSP method is designed to help clients review their past and reconstruct some of the events that shaped the present and will shape their future. One effective component of this intervention is its ability to increase the client's awareness of what is internalized. The therapist assists the client in taking his historical experiences and enrolling them as symbolic objects or role-playing figures, so what is in his mind's eye is replicated in the room. This enables him to observe himself, and provides him with more resources than his own inner self-talk. This is done in group and individual counseling settings. In the group counseling setting the client can choose to enroll objects or he can enroll observing peer participants as role-playing figures. These peer participants role play needed historical figures to help reinforce and contextualize the appropriate interpersonal protection, safety, and nurturing that was absent in the original trauma. The Role played event then becomes a corrective experience that counteracts the neglectful or even abusive behavior of the original negative figures. This event is recorded in the mind as a corrective memory. These settings Pessó refers to as *Structures*. According to Pessó, "The end result is a hopeful, more optimistic person with an ego-structure more able to regulate and control both the inner and outer domains." Pessó further describes PBSP's

Though this therapeutic process is by nature symbolic, representative, the client's experience is anything but artificial. When the desired interactions and corrective behavior are seen with the client's real eyes and felt with the client's real body, the impact on the client is dramatic. The new

experience of the desired interaction feels so memorable and believable that it can form and create a new memory. The new memory is not an abstract construct; it is a felt experience of great power. What makes it symbolic is that the client shifts the locus of the storage of that memory from a short- term “happening right now” location, to a long- term “it happened when I was a child” location. This shift in time, age, and place is what gives the structure the power of long-term memory. (Pesso, 2003, p.16).

On Fridays I run an AMAC (Adults molested as children) group. In this group we use PBSP structures to provide group members with an opportunity to increase awareness of deep-rooted issues that lie out of reach of their conscious awareness. In this process group members may be asked to participate in another member’s healing. The group members benefit from participating in each structure because many of the issues being worked through are similar to their own

In the following chapters, I will examine: (a) How the family’s ability to emotionally connect and attach to their infant early on impacts the long-term consequences of trauma (b) the importance of bonding and attachment and how it impacts the brain’s neuro-chemistry (c) how the failure to integrate a traumatic experience into autobiographical memory develops into PTSD (d) how chronically traumatic environments create within the child a bonding to unsafe attachments, which left unresolved lead to repetitive self-destructive behaviors (e) how the Pesso Boyden System Psychomotor Therapy (PBSP) method is an effective complimentary treatment that helps the client integrate the somatic processing with cognitive and emotional processing in the treatment of PTSD.

Chapter I: Definitions, Symptoms, and Assessment

In this chapter I will review the literature on current definitions of trauma, symptomology, and assessment for trauma. It is important to be aware of what symptoms are likely to be found in working with trauma clients because they will benefit in the client's assessment. Assessing which type of trauma and which type of trauma client you are treating will help in determining the goals and treatment plan.

Definitions of Trauma

Babette Rothschild, a psychotherapist who specializes in traumatic stress, distinguishes between stress, traumatic stress, PTS, and PTSD (Rothschild, 2000). Stress is basically a response to any change, good or bad. Marriage or divorce, getting a new job or being fired, and moving or losing your home are some examples. Traumatic stress results from a traumatic incident. When it continues after the incident, it is defined as Posttraumatic Stress. When it continues to the level of symptoms described in the DSM-IV, it becomes Posttraumatic Stress Disorder.

What distinguishes people who develop posttraumatic stress disorder (PTSD) from those who are temporarily overwhelmed by a traumatic incident is that they have become *stuck* on the trauma, and keep re-living it in thoughts, feelings, or images. The three most significant predictors for developing PTSD are a person's resilience, vulnerability, and social support system (Kulka, 1990 and McFarlane, 1988, as cited in van der Kolk, 1994). PTSD consists of a set of symptoms that mirror the physiological dysregulation and lack of integration of numerous intricate networks of implicit and explicit memory (Siegel, 1999).

Current research shows that the neural circuits that control the body's stress reaction and support survival are positioned in the right brain, which develops earlier than the left

brain. (Wittling, 1996, as cited in Solomon & Siegel, 2003), and is thus influenced by the attachment the child experiences during the first two years (Shore, 2002). Current research also shows a strong correlation of childhood abuse and neglect with brain development and affect dysregulation (de Bellis, M. D., 1999). Social, interpersonal stress, or attachment trauma, has so much more impact on a child than a natural disaster that these interpersonal stresses are now seen as a precursor to PTSD. Further, interpersonal stress outweighs any inherent, biological, psychological or interpersonal resilience (de Bellis, M. D., 2000).

Judith Herman, a pioneer in the study of PTSD and the sexual abuse of women and children, does not find the DSM definition of PTSD sufficiently complex to fit the wide range of trauma experiences (Herman, 1997). The DSM diagnosis does not account for the complexity found in survivors of a prolonged, repeated trauma. The current DSM diagnosis describes survivors of combat, disaster and rape. Judith Herman's diagnosis (see Appendix A: Complex Post-Traumatic Stress Disorder) encompasses the clients that have suffered massive amounts of multiple traumas and lack the resources and resilience to overcome them. Many of these clients have suffered at the minds and hands of others, either through neglect in their developing years, or from being actively victimized by others at any age. Examples are abuse, assault, rape, incest, war, torture and domestic violence. The earlier the traumatic events occur in a person's life, the greater the damage to the victim's ability to trust others and leave behind their fixation with re-living the event!

Symptoms of Trauma

Evidence during the past decade supports the notion that it is the intrusive reliving, rather than the traumatic event itself, that is responsible for the complex biobehavioral

change we call PTSD (Greenberg, Cicchetti, & Cummings, 1990). Trauma impedes the development of a healthy, integrated, complex, self-protecting system. When an abuse victim's mind and body are repeatedly overpowered, the victim experiences a variety of anxiety states. This is manifested in the symptoms of PTSD. Herman (1997, p. 35)

categorizes these symptoms as follows:

1. Hyperarousal – reflects the persistent expectation of danger
2. Intrusion – reflects the indelible imprint of the traumatic moment
3. Constriction – reflects the numbing response of surrender

Hyperarousal is a state of constant alertness that is activated after a traumatic experience, and persists long after the danger is gone. The victim's physiological arousal is triggered even if danger is not present. Hyperarousal can produce elimination problems, sleep difficulties, night terrors, and eating or digestive problems. All of this bodily discomfort results in powerful and uncontrollable emotions. Sadness, a sense of aloneness, and depression are common symptoms victims of abuse confront.

After a trauma, fairly small and insignificant daily events can trigger the original memory. During intrusion, the victim relives the event either as a flashback during waking states or as a traumatic nightmare. The victim is unable to develop a sense of well being when faced with the repetitive intrusion of trauma into daily life. Often the victim has no words to describe the intrusion because the traumatic memories are preverbal and embodied through the senses. Recent research shows that early childhood traumatic stress hinders the performance of the frontal lobe (Birnbaum, Gobeske, Auerback, Taylor, & Arnsten, 1999). The brain area that helps put feelings into words is called the Broca's area. This area and the dorsolateral prefrontal cortex are affected when processing a traumatic experience (Rauch et.al., 1996 and van der Kolk, 2002). Intrusion as a reactive

imprint may lead children who are sexually abused to reenact the sexualization by over-sexualizing themselves and others. For example, a victim of molestation might habitually view others as sexual objects or as sexually desiring her/him.

Victims who feel powerless because of a traumatic event may become paralyzed, entirely shutting down their defenses. This is relived as constriction, a defense in which the trauma victim escapes from a situation not by action in the real world, but rather by altering her state of consciousness. Traumatized people who do not experience constriction may use other numbing agents such as alcohol or drugs.

Judith Herman describes the trapped existence the trauma victim experiences:

Since neither the intrusive nor the numbing symptoms allow for the integration of the traumatic event, the alternation between these two extreme states might be understood as an attempt to find a satisfactory balance between the two. But balance is precisely what the traumatized person lacks. They find themselves caught between the extremes of amnesia or of reliving the trauma, between floods of intense, overwhelming feeling and arid states of no feeling at all, between irritable, impulsive action and complete inhibition of action. (Herman, 1997, p. 47)

The balance Judith Herman refers to is in the ability to self-regulate affect. For example, children who are chronically abused or neglected most often feel a sense of uneasiness that can escalate into anxiety, panic, rage, and despair. As adults, these symptoms often become chronic.

Victims will dissociate to detach from the abuse. They will continue to use dissociation to detach themselves from the PTSD symptoms of the trauma and even from stress in their daily life. This prevents them from experiencing new ways to cope (Shore, 2002). Dissociation occurs when the mind cannot tolerate a traumatic event and responds by shutting off the experience from consciousness. This results in the fragmenting of the mind into many different parts. Dissociation can take the forms of analgesia (physical

numbing or not being present), amnesia, denial, cognitive confusion, depersonalization and identity disturbance and fragmentation. Although dissociation can occur in the mind, it more commonly occurs in the body as it inaccurately reacts to a distorted perceived threat (Scaer, 2001).

What often happens is that the part of the victim that detaches gets deeply buried so that he/she has difficulty reintegrating that part of himself/herself. This leads to debilitating anxiety, panic, anger, and hopelessness reactions. The client is in effect trapped in this state of repetitive behavior which can manifest itself in self-destructive behavior. Those who use self-destructive behavior usually report feelings of dissociation before engaging in the behavior. They are trying to replace the emotional pain with physical pain. The way the victim adapted as a child helped the child survive in an environment of chronic abuse. Chronic abuse is stressful to the child because he/she is stuck in what Main (1990) refers to as *fright without solution*. The child is afraid of the abusive caregiver, who is also the person he/she looks to for comfort. Adaptive behavior also allows the child victim to pretend that everything is normal, forcing the symptoms to go underground, creating a *false-self*. A *false-self* is a protective persona created to cover or hide the real self from the world. The real self can remain hidden even through adulthood.

Assessment of Trauma

Assessing the type of trauma a client has suffered is vital in determining a treatment plan. PBSP structures, an approach that evaluates the internal resources available in the inner world of the client, are helpful and informative in assessing clients. The PBSP structure also can be used with all the trauma types described below.

Lenore Terr (1991) has distinguished two types of trauma victims: Type I and Type II. Type I refers to those who have experienced a single traumatic event. Type II refers to those who have been repeatedly traumatized. She further distinguishes two types of type II trauma individuals. Type IIA are individuals with multiple traumas who come from stable backgrounds. This environment provides enough safety for the internalization of resources so that the individual can separate the individual traumatic events one from the other. This person can deal with each trauma one at a time. Type IIB individuals are those who are overwhelmed by multiple traumas resulting in an inability to separate one traumatic event from the other. Studies have shown that when individuals try to recount their trauma, the Broca's area of speech in the brain shows less activity. This is consistent with the symptom of alexithymia, the inability of PTSD survivors to express emotion in words (van der Kolk, McFarlane, & Weisaeth, 1996).

Type IIB individuals can be divided into two categories. Type IIB(R) is someone with a stable background, but with a complexity of traumatic experiences so overwhelming that she can no longer maintain her resilience. Typical of this type are the Holocaust survivors. Type IIB(nR) is someone who never developed resources for resiliency. The child develops the most vital resources necessary to rebound from trauma in Erickson's first stage of development, Basic Trust versus Mistrust (Crain, 2000). In this stage, the child's needs are consistently, predictably, and reliably met by the caretakers' responses. When these needs are met, the baby develops a sense of trust and dependability. If trauma occurs in this stage, the child is less likely to evolve into the next stage of development. With Type IIB(R), the therapist is helping the client get back in touch with his/her resources. With Type IIB (nR), the therapeutic relationship is

providing the resources needed for the development of resiliency and helping the client create the resources never formed.

The PBSP structures help the therapist to determine which of the client's resources need to be reinforced, and which resources are nonexistent and need to be established. Diane Boyden, co-founder of the Pesso Boyden System Psychomotor Institute, conducts this assessment by gathering historical and current interpersonal information while observing the client's body and expressions. Take for example facial and postural expressions of emotion. Donald Nathanson (1929) described some as follows:

Muscular tension, particularly in the jaw and shoulders - anger

The rising of heat, particularly in the face - shame

Nausea – disgust

Deep breathing, sighing – happiness

Racing heart, trembling – fear

Wet eyes, lump in throat – sadness

By observing these body manifestations of emotion Diane Boyden receives significant data to identify the issues the client probably needs to address. She determines the age at which the subject experienced the trauma and identifies resulting emotional patterns that have evolved. When someone describes a physical symptom, for example cold hands, it is a diagnostic clue as to how their body has handled unwanted feelings, either by shutting itself down, or creating tension in the part of the body that wants to act on the emotion. The process of exploring bodily emotion enables Boyden to obtain a clear idea about the origin and meaning which is very important for the Type IIB (nR) because they may not be able to verbalize the emotion. (Boyden, 2003).

It is necessary in treating the adolescent or adult patient who is already symptomatic, to understand how his/her acting out reflects how he/she is connected or bonded to the

pain of the past. Jan Hindman (1999) believes that trauma bonding is stored in the memory and that the victim rarely knows how it is triggered. This creates an ongoing vulnerability preventing the person from breaking out of unhealthy patterns in relationships. Ms. Hindman has a new approach: assessing the trauma by examining the parental or family inter-relationships. She identifies which supportive relationships the victim was accessing most frequently during the traumatic period. If the victimizer was not the chief source of nurture for the victim, trauma would have less impact. If the perpetrator was the main source of nurturing, the trauma was greater. If the victim was not convinced she was responsible in granting the victimizer the trauma opportunity there was greater chance for healing. The issue is identifying the perpetrator and putting him/her in his/her appropriate role.

Chapter II: Attachment Theory

Attachment theory provides a useful theoretical outline for understanding the impact of family background on long-term consequences of trauma. Patterns of insecure parent-child attachment are frequently found in families characterized by abuse. In this chapter I will address (a) how the family's ability to connect and attach impacts the long-term consequences of trauma, and (b) how the family's lack of attachment sets up childhood abuse. Research over the last century shows that the security of the parent/child attachment significantly impacts the child's ability to rebound from trauma.

One cannot discuss issues related to self/object attachment without first discussing the work of Bowlby, Ainsworth, Main and Solomon. Bowlby (1907-1990) began his inquiry regarding attachment when he became troubled about disturbances of children raised in institutions. Children who grow up in nurseries and orphanages, he discovered, often showed a variety of emotional problems, as well as an inability to form intimate and lasting relationships with others. Bowlby thought such children were unable to love because they missed the opportunity to form a solid attachment to a mother figure early in life. He also observed parallel symptoms in children who grew up in normal homes for a while but then experienced prolonged separations. These children seemed so affected that they permanently turned away from close human ties. Bowlby also noted that during these traumatic separations, some young children also became disorganized. Such observations convinced Bowlby that one cannot understand development without paying close attention to the mother/infant bond. How is this bond formed? Why is it so important that, if disrupted, severe consequences follow? (Ainsworth & Bowlby, 1991) The need for close attachments is built into our nature.

Ainsworth described the innate attachment during infancy as follows:

1. A persistent desire for closeness to one or a select few persons who are usually biological relatives.
2. The propensity to use these persons as a safe foundation for exploring the unfamiliar.
3. Flight to the attachment figure when anxious.

First attachments are ordinarily formed by seven months, develop with only a few persons, and are based upon social interactions (Ainsworth, 1967, as cited in Crain, 2000).

Bowlby's theory is that a child's attachment mirrors animals' attachment and imprinting period. Bowlby articulated the biological background to the human infant's attachment by comparing the similarities in monkeys and apes. An animal will quickly learn which objects are safe to follow. He believes these patterns develop as a function of an attachment behavioral system designed to insure immediate survival and future reproductive success. In his view, this system is as innate as our feeding and reproduction patterns. Maintaining proximity to the attachment figure is the infant's primary means of survival. When a child doesn't develop healthy attachments, there is room for a perpetrator to come in and be received by the child. If the infant is insecure and ambivalent he develops an inability to protect himself, leaving himself open to invasion of his boundaries (Miller, 1994). The child does not know who to fear and what is good nurturing because the mother dissociates, continually pushing the child away. After a certain period of time, an innate fear response restricts the ability to form new attachments. This process takes the human baby about 6 months.

Ainsworth (1967), like Bowlby (1969) believed that all infants, unless raised in abnormal conditions, would form an attachment by the end of the first year. Thus, the

biggest issue for normally raised toddlers is not whether they become attached, but how their attachment to the primary caregiver is organized

Mary D.S. Ainsworth looked at how ordinary child rearing has varying degrees of healthy attachment. Ainsworth reported that *secure attachment* is the product of maternal sensitivity to children's signals and needs. *Insecure* or *avoidant* infants reflect an inability to count on mother for their needs. As a defense, the infant ignores the mother or doesn't even notice her. *Insecure* or *ambivalent* infants are a product of the mother's inconsistency: being warm and sensitive on one occasion and cool and uncaring, or even absent on another. This dynamic creates in the child an eagerness to be with mother and then resistance or anger towards her when she reappears. Ainsworth described this dynamic as *insecure-resistant/ambivalent* (Crain, 2000).

In 1990, Main and Solomon reported that approximately 13 % of infants in their research did not fit any of Ainsworth's original three categories. This aligned with the findings of those working with abused children that not only was there a lack of categories for these children, but that if they were to categorize them, they would fall in the *secure attached* category. To better understand this dilemma, Main and Solomon reviewed the research videotapes. Instead of finding a pattern of behavior to define a new category, they found a lack of pattern. These children exhibited bizarre, peculiar, or blatantly conflicting behaviors. The most remarkable behavior pattern they saw was that of *disorganization* (Main & Solomon, 1990). They added the term *disorientation* to describe behavior that does not look disorganized, yet these children appear to lack the ability to locate themselves in their environment with reference to time, place, and people.

This form of insecure attachment has been associated with impairments in the emotional, social, and cognitive realms, and an inclination toward dissociation, as well as an inability to operate in a clear and organized manner. This illuminates understanding of how trauma is transferred from one generation to the next (Solomon and Siegel, 2003).

Main and Hesse (1999) theorized an explanation of how a parent's unintegrated, detached and disconnected state could be related to the disorganized behavior in the infant. Each of the following states of parental behavior can scare the infant:

1. Frightening or threatening behavior;
2. Fear and anxious behavior;
3. Detached and disconnected behavior.

If the parent's own traumatic experiences are not resolved, the parent might also exhibit the following behaviors:

4. Sexualized behavior;
5. Treatment of the infant as the parent or protector;
6. Erratic, disorganized and/or disoriented behavior.

Siegel and Solomon are in agreement with the attachment theorists. They believe that "children are born with an innate need to be attached to their caregivers" (Siegel and Solomon, 2003, p. 37). The attachment processes includes seeking close physical contact with their attachment figures, turning to the attachment figure for soothing when distressed, and internalizing these relationships so they can access a sense of security when separated from their caregivers. The attachment figure is supposed to be the child's protector, soother, connector, and source of joy. Instead, the child who develops a disorganized attachment experiences the caregiver as a source of terror and fear, so cannot turn to the attachment figure to be soothed.

The basic elements for secure attachment are:

1. Contingent Communication: A form of communication connecting child and parent that allows the child to feel understood and complete. This involves a) perceiving the child's verbal and non-verbal signals, b) making sense of the signals, and c) responding effectively and quickly.
2. Reflective Dialogue: When parents go beyond discussing visible objects to a deeper layer of human experience, they help the child form *mind sight*. These deeper experiences are thoughts, feelings, sensations, perceptions, memories, attitudes, beliefs and intentions.
3. Repair: When we need connection to others and it does not occur, this is called *rupture*. Repair is an interactive process that involves an acknowledgement of the disconnection and an attempt to move forward and reconnect.
4. Emotional Communication: Securely attached children often have a form of emotional communication with their parents that involves: a) the sharing and amplification of positive emotions, such as joy and excitement; and b) the sharing and soothing of negative emotions, such as fear, sadness, and anger. Sharing of emotions allows a child to learn that emotions are tolerable internally, and can lead to a rewarding sense of closeness interpersonally. Negative emotions can be seen as an opportunity to deepen a child's capacity for self-regulation and self-understanding. This process creates the interpersonal experience of empathy and compassion.
5. Coherent Narratives: This is about storytelling and is a vital form of interpersonal communication and internal understanding. Narratives help us to make sense of our lives and of other people. Stories enable us to understand the complex social worlds in which we all live. Parents who have come to make sense of their own early life relationships have the highest likelihood of having children who are securely attached to them (Siegel and Solomon, 2003, p. 38-40).

As described by attachment theory, children provide us with responses and signals that must be heeded if development is to proceed properly. Research has demonstrated the crucial importance of the parent's focus on the child's subjective experience for the

development of the child's well-being. The most fundamental need of the young child is effective communication with the caregiver. Without this, the young child is not able to regulate fearful stimuli, or consciously understand an accurate response (Shore, 2002). Further, the parents own subjective internal comprehension, and how they make sense of their own histories is the greatest predictor of their child's development of a secure attachment to them. These research findings accentuate the central importance of the internal and inter-personal subjective states in the emergence of well-being.

Chapter III: Trauma and Neuroscience

The Brain, Attachment, Development and Memory

Current research in brain development and attachment has illuminated how early relationships influence such basic functions as memory, emotion, and behavior regulation. Discoveries in neurobiology and attachment are coming together to deepen our understanding of trauma. This chapter discusses the importance of bonding and attachment, and their impact on brain neurochemistry. It also shows how failure to integrate a traumatic experience into autobiographical memory develops into PTSD.

Science recently has developed methods of mapping brain processes, on both an anatomical and a functional level. Visualizations show where memories and emotional experiences are stored in the brain. Experiments have shown that when a person works at consciously storing information, the hippocampus probably plays an important role. The brain stores memories by breaking them down into components then putting them in separate compartments. We learn such processes as riding a bike or performing a dance routine, step by step, before they become habitual, automatic routines.

During the past century, research into the consequences of trauma, and effective treatment for it, has yielded consistent results. van der Kolk and van der Hart (1989) cite Pierre Janet's belief that an event becomes traumatic when a powerful emotional reaction prohibits the experience from being integrated into existing memory schemes. Janet held that powerful emotions cause memories of certain events to be split off from consciousness, and saved either as body sensations such as anxiety, or visually in the mind as nightmares or flashbacks. He also saw a pattern of trauma victims experiencing severe symptoms in reaction to a reminder of the traumatic event. The symptoms seen were an appropriate response to the original event, but not to their current reality. These

victims seemed incapable of moving past the traumatic event to live in the non-traumatic present. Instead, they were obsessed with controlling their symptoms. They became absorbed in their past, sometimes focusing on the traumatic event, but more commonly repeatedly re-experiencing the feeling and behaviors associated with the trauma without understanding the roots of these feelings. Freud also believed victims were biologically predisposed to obsession with their trauma (van der Kolk & van der Hart, 1989, 1991).

The central organizing system for emotions and behavioral input that helps us to survive is the limbic system. Sensory organs constantly send signals to the thalamus, which disburses them to the cortex, setting up a *stream of thought*, to the basal ganglia, setting up a *stream of movement*, and to the limbic system, setting up a *stream of emotions* (Papez, 1937, as cited by van der Kolk, 1994). Van der Kolk (1994) believes that most sensory input is processed unconsciously, and only new significant or threatening information is sent to the neocortex for additional processing. The amygdala and the hippocampus are the components of the limbic system that process emotional memories.

Calvin (1990) believes the amygdala is responsible for internalizing the external world by associating symbols and images to memories. The amygdala gives meaning to the sensory input and sends it to the hypothalamus, hippocampus, and basal forebrain.

When attachment experiences are not good, mental processes may function in ways that do not promote healthy well being. Siegel and Solomon refer to these processes as organized adaptations. Those who have suffered severe childhood abuse have some severely underdeveloped areas of the brain. (Siegel and Solomon, 2003). Specifically, research has found the corpus callosum, the bands of neural tissue that transmit messages

between the two halves of the brain, to be underdeveloped (DeBellis, 1999). If the cerebellar vermis is damaged and unable to support the inhibitory gamma amino butyric acid input to the hypothalamic nuclei in the brain stem, the individual loses the soothing function of the limbic system. Without this soothing function, excessive stress hormones are secreted, and the child loses the ability to integrate mental processes across the brain, which also disables his/her ability to emotionally soothe himself/herself.

During a traumatic event, the limbic system as the interpreter of arousal stimulates the autonomic nervous system (ANS) to contend with the danger. This is a normal, healthy, adaptive survival response. In PTSD, the ANS remains chronically aroused, even though the danger is gone and the victim has survived. The difference in normal and PTSD response to threat is illustrated in the diagrams in Appendixes B and C adapted from Rothschild (2000).

Attachment, Neural Integration, and Trauma Resolution

In insecure attachments, neural integration is compromised, and can thwart the brain's capacity for complexity. Neural integration is a central, self-organizing mechanism that connects the many separate internal and interpersonal processes into a coherent and functional whole. A person's ability to understand and relate his life story reflects the ability to perform this integrative process. Interpersonal integration is demonstrated when one brain is able to exchange information with another brain.

According to Solomon and Siegel (2003, p. 42),

Neural integration of the processes dominant in the left hemisphere with those dominate in the right can be proposed to produce a *bihemispheric* integration which enables coherent narrativization. The left hemisphere functions as what has been called an *interpreter*, searching for cause-effect relationships in a linear, logical mode of cognition. The right hemisphere is thought to mediate auto-noetic consciousness and the retrieval of autobiographical memory.

The right side also dominates social cognition and information processing. Thus, coherent narratives are a product of the integration of left and right hemisphere processes across time and hemispheres.

Emotion is the core of neural integration. Balanced emotion is intrinsically integrative, connecting compartments together in a well-designed whole. A healthy, integrated mind is flexible and flowing with information. Unbalanced emotion may be revealed in inflexible or chaotic states, as seen in various forms in posttraumatic stress disorder, reflecting an inability to achieve complexity. Emotion is also an essential part of self-regulation. In unresolved trauma, integration, self-regulation, and emotion are damaged, and a lack of resolution causes an inability to conceptualize the traumatic event. This in essence creates a block in the mind's flow of information and energy. This block inhibits information flow within the trauma victim's mind, and between his and other minds.

These blocks further create states of excessive rigidity (numbing, avoidance, withdrawal) and chaos (flashbacks, intrusive memories and emotions), manifested by the inability to adapt to changes in the internal or external environment. Such rigidity contributes to internal and interpersonal dysfunction. Dissociation is one byproduct of lack of resolution of trauma and lack of integration. Another unresolved state comes in the form of flashbacks (Siegel, 1995).

One overall method of psychotherapy is to help individuals with unresolved trauma by developing their mental aptitude for complexity, in both the internal and external environments. When effective, this approach allows the client to learn how to self

regulate, process emotions, stabilize moods, and tolerate change. These processes reflect the mind's ability to handle complex states.

The ability to integrate may be at the center of mental health. Finding ways to facilitate integrative processes within and between individuals may enable us to help others grow and develop. Attachment and effective psychotherapy can advance neural integration. Stored memories determine how we view and interpret our present day life. We have an innate sense of a balance between healthy and unhealthy emotions. These emotions are stored in the memory compartments in the brain, and Pessó's structures, EMDR, and other forms of therapy provide a place to rework some of this neural networking compartmentalization. Research shows that the brain can redevelop neural paths to bring in new emotional information and relieve the blocks, letting the energy flow.

The traumatized client often lacks positive emotional memories of protection and nurturing. PBSP role-playing allows the client to symbolically have these needs met. The goal of PBSP is that the neurons will put a new imprint on the neuron cell and the cell will go into storage, replacing the old, negative memory. It is important in therapy to review the client's life experiences. Even more important is for them to relive it as a positive experience. They must experience it bodily and emotionally to see that it really is possible to have a positive outcome at the right age and in the right kinship relationship.

Attachment and Neurochemistry of Bonding

Important contributions by Cozolino (2002) include the importance of the eyes, the neurochemistry of bonding, proto-conversation, sensitive periods, and the neural networks of the social brain. Early in infancy, the gaze between children and their caretakers is the main way the infants' brains grow and are organized. Eye contact is very

important both to a child's caretaker and to a psychotherapist. As toddlers separate from their parents, they look to the parents' faces as a safety gauge. A calm expression on the parent's face provides the toddler with the confidence to continue exploration. A frightened expression may cause the child to decrease or end the exploration and return to the parent. A patient's reaction to a psychotherapist's gaze can be a reflection of the patient's earlier bonding place. The patient may want to be looked at, to feel important to the therapist, or may feel uncomfortable with a gaze. Each reaction shows how the patient's eyes trigger the networks of his social brain. The amygdala takes in the information seen and tells the limbic system whether it is safe or dangerous.

Mother-child bonding neurochemically creates positive feelings, pain-reduction, and a sense of well being through the release of brain chemicals. "Higher levels of endorphins make us feel safe and relaxed, whereas low levels stimulate behavior designed to increase proximity, caretaking, and a sense of safety" (Cozolino, 2002). Opioids are responsible for the infant's bond with the mother and his/her sense that the world is a safe place. Even as our bodies respond to the sensation of pain and our brains integrate that sensation with our knowledge of the environment in which it occurs, the opioids produced by the brain lessen our perception of painful nerve signals, protecting us from fully feeling them. Pessó believes the infant internalizes the mother's image of himself through experiencing events involving the body, mind, and emotions. Pessó refers to this developmental stage as "Place". Through the gaze they know they are living in the consciousness of the parent, they have a place in the parent's heart. Therefore the parent is remembering and seeing him in her mind's eye, he has a permanent image/imprint in the parent's. The child feels at home in his own body, "fittedness", in their self, and in

his world. During times of stress these events can be recalled and used to regulate affect. Endogenous opioids make internalization of the mother's image happen.

Cozolino (2002) refers to the preverbal communication between mother and child as proto-conversation. He believes, that mothers communicate a feeling of safety to their infants even during pregnancy. This communication continues after the baby is born: "The social and emotional context of interactions over the first year of life serve as the interpersonal and emotional scaffolding for the semantic language to follow". (Cozolino, 2002) In this first year, the right side of the brain undergoes rapid development and creates the ability to verbalize ones emotions.

This is not just one-way communication. Babies learn both how to respond to their mothers and how to affect the mother's response. Through an active interplay between baby and mother, the mother's response to the baby helps the baby organize and internalize emotions and behavior. This internalized emotional language is the mother's core lesson to her child as to how to discern danger. "This is the language of intersubjectivity, in which the child learns from the mother about the fundamental safety or dangerousness of the world." Cozolino believes that this stage of internalizing the emotional language is critical for the child to be able to tell his story in the context of emotional, psychological, and social conversation.

Cozolino defines the times of explosive growth and development of connections in a particular neural network as sensitive periods. These periods are activated both biologically and environmentally. As each network is developed, the child can master new tasks that the network controls. Attachment and affect regulation are developed during sensitive periods early in life before the development of conscious awareness. If

the child does not have a positive bonding and attachment experience, the neural circuits in the social brain lack the ability to attach and bond, and these inabilities are carried into adulthood. As adults, these individuals will relate to others the same way they viewed the early relational experience and have difficulty changing.

The social brain is made up of different neurological components including the amygdala, the anterior cingulate, the orbitofrontal areas of the prefrontal cortex, and the frontal portions of the temporal lobes. The amygdala, which helps us to distinguish safety from danger and activates many fight-or-flight responses, is another important part of the social brain. It works alongside the orbital area of the prefrontal cortex (Ofc) to help us determine the trustworthiness of others. The Ofc is considered the core of the limbic system. Because it is the mediator for multiple senses and emotional information as it guides and directs the hypothalamus, it is directly responsible for processing information about our external and internal worlds. This neural functioning enhances our ability to reflect, and to communicate with one another.

Understanding the scientific findings on bonding and attachment impact the brain's neurochemistry provides the therapist with a more complete understanding of the trauma victim client. The therapist can better understand the client's limitations and determine appropriate interventions. The client's ability to tell his/her story in a meaningful and understandable way, and, to understand how it impacts his/her life today produces hope for the future. This enables trauma clients to take ownership and responsibility for their lives, integrating new information into their brains, and opening themselves up to more satisfying connections with themselves and others.

Chapter IV: Internalizing Resources

All humans start their lives internalizing their primary caregiver's resources. This internalization is "not a memory, nor a representation, it is part of the self's being" (Scharff & Scharff, 1992, p. 5). This chapter addresses: (a) how the family's ability to emotionally connect and attach to their infant impacts the long-term consequences of trauma (b) how chronically traumatic environments create within the child a bonding to unsafe attachments which when unresolved lead to repetitive self-destructive behaviors.

Margaret Mahler shows how babies within a relationship become separate from their caregivers (Crain, 2000). Her work is important in understanding the way in which infants internalize the resources of their caregivers and how traumatized children can stay bonded to their trauma. In the normal symbiotic phase, approximately the first through the fifth months, the child starts taking pleasure in the mother's smell, touch, tone of voice, and the ways she is being held. In this stage the baby does not know he is separate from the mother. Mahler calls this the undifferentiated state. The infant's ability to separate his or her internal experiences from external experiences is not developed. This stage is what Erickson defined as the crucial stage for the development of basic trust (Crain, 2000). Mahler called this sense of unity with the mother a *safe anchor*. In the normal autistic phase (from birth through the first month), Mahler says the newborn is in an inner physiological state, paying attention to inner sensations, not the outside world or outer sensations. In the separation/individuation phase (from five to nine months), Mahler believes the baby is innately driven to explore its outside world. She is keenly aware of outside objects and starts to explore by rolling over, touching and grabbing. Mahler says the baby has *hatched*, moving out and away from the mother, finding new interests, and experiencing fears.

Pesso (1991) refers to the normal symbiotic stage as a stage of *ego-wrapping*, where experience is wrapped with consciousness. The child's core being is made up of energy that does not yet have an ego skin. The parents' reactions to the child shape and countershape (ego-wrap) the child's inner world. There are three steps in the ego wrapping process. "The first stage is *need satisfaction* where our basic needs must first be met literally and concretely by parents and caregivers who conceive, feed, carry, defend and limit us" (Pesso, 2003, p.13). Mothers that cannot handle the child's needs during this stage may abandon the baby, allowing her to cry. "The second stage is another *need satisfaction* where our basic needs must be met on the symbolic level by parents and caregivers who give us a place in their hearts, nurture our self esteem, support our efforts, protect our rights and limit/define our boundaries" (Pesso, 1994, p.14). "The third stage is *self-reliance*, where we learn to satisfy our own needs. Having internalized the caregiving of others, we have a place for ourselves in our own minds and bodies, and can nurture ourselves with our own efforts, support ourselves, protect ourselves, and limit ourselves in our own and the community's best interest" (Pesso, 1994, p.15). Trauma victims may get to the separation stage with an unhealthy sense of internalized resources or absent resources altogether. Dusty Miller (1994) identifies three aspects of the triadic self that reflect unhealthy internalized caregiver states:

1. The victim--the wounded child within
2. The abuser--an internalized representation of the abusive adult
3. The non-protecting bystander--usually a representation of the adult figure who was unable or unwilling to protect the child victim

Dusty theorizes that these internalized parts of the self play out in self-destructive behaviors and relationships. The internalized voice of the abuser is dominant and dictates

the behavior. The internal timorous voice is the victim trying to stop the behavior. The voice of the internal non-protecting bystander sounds impotent, thereby creating a greater sense of being overpowered. Miller believes that “every time a woman engages in self-harmful behavior, she is fragmenting herself into the triadic self-configuration: the abuser harms the victim, and cannot be stopped because the non-protecting bystander is incapable of intervening” (Miller, 1994, p. 32). In treatment then, it is necessary for an internalized protective parent resource to be established to replace the non-protective voice. According to Miller, this is both the most difficult part of recovery, and the most important.

In contrast, according to Pesso a person does not have the necessary internal resources to become his own parent before experiencing parenting in historical time at the appropriate age. Requesting a client in this position to parent himself, hurts him by prematurely giving him the parenting duty before he has experienced being parented. PBSP helps create this necessary new memory, so that the client can build resources with the appropriate foundation. Pesso in his structures recreates the traumatic event and restructures past emotional reactions and expressions. He has the client enroll an idealized protective parent that the client instructs to react in the way the client would have desired in the actual event. This intervention creates a memory of an externalized protector figure outside the client so the client can internalize the resources of this new symbolic representation. Pesso would say these are not internalized people, but actual historical players experienced in the client’s mind. What is internal is the lack of what could be and the memory needs to be replayed in a way that the wounding does not happen. The antidote is an internalization of a simulated experience of growing up in a

loving, caring environment where such wounding things could never happen. Experience of the rightness of the new memory helps build the self.

Judith Herman (1997), describes the child in a healthy, attached environment who internalized the resources of a secure and safe caretaker able to handle the stresses of the world. In an abusive environment, the child cannot form these internal representations because of a continuously chaotic, traumatic climate. Without good, safe, inner resources, the child depends on external sources for soothing. Because the child feels no inner security, he or she is unable to feel autonomy, and continually looks outside him/herself for someone who can provide what he/she lacks.

When a child develops in a chronically traumatic environment, instead of a healthy environment, the imprinting process creates unsafe attachments. Dusty Miller's Trauma Reenactment Syndrome, refers to women who hurt their bodies as a consequence of childhood histories of interpersonal trauma where they were not protected. These women repeat the damage done to them as children. As they hurt their bodies, their belief is strengthened that they are not able to protect themselves where they were not protected. Steven Levenkron (1998) says this kind of damage causes the child to fuse love-attachment-abuse into a single cluster of feelings. If a parent physically abuses the child while verbally declaring love or care, the child's desire for attachment becomes the glue that fuses these two contradictory messages. This results in the self-infliction of pain as a way of dealing with loneliness and the need for parental companionship. The behavior of harming oneself fulfills many needs. It keeps others away, numbs feelings of loneliness, substitutes for a relationship, provides life-giving substance for the internal void and deflects feelings of rage, anxiety, depression and sadness. The client I will describe later

in a PBSP structure case study, felt safer in her destructive pattern than in choosing healthy solutions.

The central characteristics of Trauma Reenactment Syndrome are:

1. The sense of being at war with one's own body
2. Excessive secrecy as a central organizing principle of life
3. Inability to self-protect, often evident in a specific kind of fragmentation of the self
4. Relationships in which the struggle for control overshadows all else (Miller, 1994)

Attachment to repetitive self-destructive behavior, for example, self-mutilation, drug addiction, eating disorders, compulsive sexual behavior, compulsive risk-taking or exposure to danger, creates and sustains the illusion of control over one's body. This is important since the abused, neglected or invaded child lacks control of his body. In addition, self-destructive behavior often provides a sense of relief from possible rage, grief, numbness or anxiety.

Women who are affected by trauma seem to others to be out of control. Yet, the woman harming herself feels in control of her body. She may be mutilating herself, bingeing and purging, starving herself, having unprotected sex, but she is still choosing to do these things to herself. Since her body was overpowered as a child through abuse, neglect, or violation, she longs for a sense of control. The self-destructive behavior can help relieve many different symptoms such as sadness, depression, anxiety, numbness, emptiness, or murderous rage. Sadly, it is the dissociative processes that helped a child early on that now prevent achievement of healthy boundaries in adulthood. Pesso uses a method called *Conscious Voluntary Movement* to help a trauma client to function adaptively in the outer world and regain mastery of his emotions from cut off feeling

states. Pessó says when there is trauma (explosion of power) the body itself becomes dangerous, so a person through dissociation leaves it. Conscious Voluntary Movement can help a person to take ownership of his body. These exercises help promote how to reenter the body and encourage control by facilitating voluntary movement of the body in a free state. The person exercises conscious control over body.

The need to control relationships is the final key feature of the trauma re-enactment syndrome. This feature helps explain the client's emotional dysregulation, outbursts, fights, and inconsistent involvement with the therapist. The trauma individual alternates between avoiding social contact and frantically clinging to people. This is a terribly unhappy experience, and explains the difficulty of establishing intimate relationships. There is a rapid shift between asking for help and then rejecting it when it is offered. Personal and professional caretakers withdraw in exasperation, which in turn is viewed by the traumatized individual as rejection, thereby reinforcing his or her mistrust of relationships as the cycle escalates. Pessó describes this dilemma as follows:

The hard-working child doesn't give up hope that it will get its own needs met. Unfortunately however, it is willing to go on that life-long detour of propping up the crippled parent in the hope that the parent will someday "grow up" and be able to return the favor and become the wished-for, longed-for parent to themselves-they were expected to be in the first place (Pessó, 2003).

This propped-up parent part of the child is a compassion-driven part *entity* that had to fill a need for the parent, or fill a hole in the role of a family member. "This compassion-born *entity* draws energy from the child that would ordinarily fall in its own soul's jurisdiction and uses it in the service not of the self, but of the other, the mother or father in need" (Pessó, 2003).

Hindman (1999) has explained an attachment to trauma bonding as the victim's natural attraction to negative energy. We are fated to be more connected to disagreeable events, perhaps out of a survival instinct. When a person has been traumatized, he is more focused on that hurt and on avoiding future hurts for survival. That negative focus is a component of the bonding. Hindman further explains that the victim is stuck in a stage of development, and hence it is painful and difficult to break out of its control.

When it is impossible to avoid the reality of the abuse, the child must construct some system of meaning that justifies it. Inevitably the child concludes that her innate badness is the cause. The child seizes upon this explanation early and clings to it tenaciously, for it enables her to preserve a sense of meaning, hope, and power. If she is bad, then her parents are good. If she is bad, then she can try to be good. If, somehow, she has brought this fate upon herself, then somehow she has the power to change it. If she has driven her parents to mistreat her, she may some day earn their forgiveness if she tries hard enough, and may finally win the protection and care she so desperately needs.

Self-blame is a natural, normal way of thinking for children who still see themselves as the center of the world. It is also normal in traumatized people. They try to make sense of the trauma by searching within. For the victim of repeated trauma, there is no experience that corrects this natural response and it is repeatedly reinforced. In addition, the family often reinforces the response by assigning the blame to the victim both for the trauma and for other family problems.

It is normal for victims of abuse to experience and express feelings of rage and act out aggression. The abused child who has not yet developed conflict resolution skills often feels out of sorts socially, and is fearful of confrontation, because it feels like an attack on

him. These feelings of rage and acts of aggression reinforce the child's feelings of badness, particularly when the rage and aggression are not focused on the perpetrator, but are inappropriately projected on someone else.

If the victim of sexual abuse derives any sense of pleasure, receives attention, is bribed with rewards, or is promised special treatment for allowing the abuse, this sends a message that she brought the badness on herself. This is reinforced by the fact that the controlling adults in her life have brought these horrible things into her world. Self-talk becomes a voice of self-disdain and self-hatred. For example, a 15-year-old victim of molestation, who just became personally acquainted with Jesus, believed that she, if anyone, would bear the antichrist. Herman (1997) describes this: "By developing a contaminated, stigmatized identity, the child victim takes the evil of the abuser into herself and thereby preserves her primary attachments to her parents. Because the inner sense of badness preserves a relationship, it is not readily given up even after the abuse has stopped; rather, it becomes a stable part of the child's personality structure" (p.105). Almost all social workers in abuse cases tell the child that she did not bring on the abuse, yet most children continue to blame themselves. This continues into adulthood, because it is so much a part of their core identity and plagues them if they do not get help. Further, it sets them up to attract additional abuse.

Usually, the abused child tries to cover the sense of badness, and please her parents by becoming a good girl, over-achiever, great performer, or perfectionist. No matter how great her performance, she can never internalize the good external acts because she doesn't believe that is who she truly is. She worries that if others see who she really is, they will reject her. If the child has to be perfect and perform at such a level, it doesn't

allow her to integrate making mistakes, or be anything less than perfect. She cannot embrace her own humanity. She lives in the cycle of perpetual guilt and shame because she cannot live up to her own grandiose standards. Usually the victim's internal representation of herself is profoundly fragmented between the bad and the good.

The victim also has difficulty with her inner representation of others. Not wanting to see her parents as bad, she usually creates her own version of ideal parents. The child might try to stay connected with the non-offending parent by blaming her badness for their lack of protection. But more often the child creates an idealized version of the parent and turns all her anger on the nonoffending parent because the abusive parent pays more attention to her.

The reality of the abusive or uninvolved parent clashes with her idealized images; therefore she cannot integrate the genetic template of what a good parent should be. She also projects a negative template into her external environment and can never feel safe and cohesive with her parents. This disables her regulation of emotions, making it almost impossible for her to comfort herself.

Five major theories address my proposed questions concerning the internalization of trauma. The first theory is that the mother-infant relationship strongly influences how a child responds to and reacts to the world around it. The second theory is that the negative behaviors of PTSD clients must be seen as a way to manage or adapt. These behaviors are an indirect way to experience the anger and pain from past trauma. The third theory is that victims internalize negative aspects of their self- image to keep their caregivers in a strong ideal role to which they can stay attached. The fourth theory is that the abuse becomes so familiar that the client is attracted to other abusive relationships instead of

healthy relationships. Abusive relationships may be experienced as more consistent and reliable than relationships with other people. The final theory is that through PBSP therapeutic intervention an alternative symbolic memory can be created and the client can internalize the resources from the consciousness wrapping around the experience and go on to live a more healthy, stable life and replace the destructive behaviors.

Chapter V: Pessó Boyden Psycho/Motor System Treatment

Albert Pessó has been called a master of body-based therapy. The Pessó Boyden System Psychomotor (PBSP) has been developed and tested for over 40 years of treating patients and instructing practitioners. Albert Pessó and his wife Diane Boyden-Pessó developed PBSP together in 1961 as they were working through some personal crises in their own lives and working towards helping their students when PBSP was born. When constructed an effective method for reframing past experiences that block present interactions. PBSP was one of the earliest somatic therapies, and is widely used in the U.S. as well as eleven other countries. In this chapter, I will show how the PBSP method is an effective complementary treatment that helps the client integrate somatic processing with cognitive and emotional processing in the treatment of PTSD.

PBSP therapy takes place in an atmosphere of safety, care and respect. The therapist carefully tracks the meaning of verbal, nonverbal, and emotional information provided by the client as this information surfaces. It involves important body-mind integration that is foundational in current brain research in psychotherapy and relates easily to all major techniques used to treat emotional and mental problems. Like psychoanalytic theory, PBSP holds that secure attachment is fundamental to development of the child's integrated self. Both theories also see the importance of a good holding environment. PBSP can enhance existing approaches that are powerless in reaching an effective remedy for PTSD. Therapists use PBSP in groups and in one-on-one situations with a wide variety of populations.

As van der Kolk and van der Hart (1989, 1991) showed, trauma victims often become absorbed in their past, repeatedly re-experiencing the feeling and behaviors associated with the trauma without understanding the roots of these feelings. The Pessó Boyden

System Psychomotor therapy method allows for an expression of feelings that are deeply stored in the body.

The body is involved, Pessó says, because physical memories are created through sensory interactions with caregivers in early life. Mother-child bonding neurochemically creates positive feelings, pain-reduction, and a sense of well being through the release of brain chemicals (Cozolino, 2002). When this does not occur or is derailed by trauma, Pessó believes that allowing the client to recreate a symbolic experience of a new safer ending, related to the early trauma, allows him or her to have a sensory experience that fills the void and improves the client's ability to cope. "The key to recovery for many psychological victims of terrorism can be found locked in the physical" (Pessó, 2002, p. 1). The PBSP therapeutic process identifies *triggers* which can release the stored energy of those impressionable events. The energy is released in the form of emotional behavior that can be acted on in the present, and remolded or given a paradigm shift that reforms the interpretation of the past event. Those emotional and somatic imprints are treated as clues leading back to specific historic events. Traumatic experience causes memories to be dissociated from consciousness, preventing them from being integrated into normal neuronal schemes. PBSP makes an alternative healing event in order to provide what should have been present so that the shattered web of memory is restored to life. This transforms the original traumatic memories and allows them to be reintegrated appropriately in the brain. It also restores healthy neural integration, which is reflected by a person's ability to understand and relate her life story (Solomon and Siegel, 2003).

For Pessó, the desired outcome is reestablishing an expectation of a good end, healthy relationships and reciprocated love. Pessó has tested his approach with trauma victims

around the world. He is convinced that using emotional experience to reframe safety allows a normal, healthy, adaptive reaction to a traumatic event. Those who become debilitated are probably suffering the after-effects of an early traumatic emotional shock. "At some time the bottom may have dropped out of their life and it was sealed over, but that memory is still locked in their body and has been reawakened by the fresh trauma" (Pesso, 2002, p. 1).

People who have been traumatized often become bonded to the trauma as described by Dusty Miller's theory (1994) or focused on avoiding future trauma (Hindman, 1999). These individuals have difficulty appreciating the beauty of the world around them. "But if you give them the satisfaction, instead of seeing all the horrors, they'll be more receptive to the good things out there," Pessoa says. He believes those most affected by trauma are without hope. "It is hope that sustains us in times of adversity," he says, "but in order to have hope, one must have a plentiful supply of memories of past satisfaction upon which to anticipate a hopeful future" (Pesso, 2002, p. 2). Creating an artificial counter event leads toward safety and a reconstruction of meaning and personal value.

The key to helping individuals emerge from despair, Pessoa says, is to allow them to "create new symbolic memories to offset the debilitating effects of past, deficit ridden, personal histories" (Pesso, 2003, p. 13). Van der Kolk (1999) refers to this as "[processing] trauma so that it is quenched rather than rekindled." This is done through a therapeutic process that Pessoa calls a *structure*, in which individuals play the role of idealized figures from the trauma victim's past, enacting a *theater of the mind* by creating the nurturing events missing from the victim's history. The brain's electrochemical impulses will quickly act on the new mental experiences now created. The expectation is

that the *theatre of the mind* will tap into the old trauma-based memories and effectively merge with them and together go through a new, more loving experience that will settle itself in the brain so that the trauma responses will no longer be controlling. (Pesso, 2003, p. 2)

The process of the structure and reenactment in the theater of the mind has proven beneficial to many clients. The Pessos first discovered through their career in teaching dance that there were certain movements professional dancers could not perform. As they researched and pursued these phenomena, they discovered that there was a basic fundamental connection between movement and emotions. Thus the concept of integration of body and emotion was born. Dance classes evolved to become therapy sessions that they later titled *structures*.

The Basic PBSP structure is made up of:

1. Contract / Setting up the rules
2. Offering the Possibility Sphere
3. Micro-tracking throughout the structure
 - a. Fragment figures
 - b. Ideal parents
 - c. Entity
4. Setting up the true scene
5. Setting up the historical scene (old map)
6. Setting up the symbolic healing scene (new map/antidote)

Contract and Setting up the rules

Before the therapist makes a therapeutic intervention, it is best to establish a clear contract with the client. In the beginning of all sessions Pessó makes sure that he and the client makes a contract with the part of them that wants to come to a good end or change. We're banking on that part of the soul to be present. "In PBSP the therapist follows the client, trusting that the emotions (felt consciously as affect and unconsciously as sensations in the body) that arose in the work contain the seeds and energy that would result in a healing reorganization of perception and action in the present" (Pessó, 2003). That the client will follow their own impulse to heal and will bring the work of a structure (the name we give to the therapeutic process) to a good end. In the structure, we review and illustrate clients' negative history with the help of role-players or objects chosen by the client to represent the figures in their past.

The therapist's observational skills are used to oversee the appropriateness and accuracy of the role-played scenario. The client describes the memories, facts and emotions, which serve as the therapist's guideposts. The contracting procedure for taking a role is very important and rules must be made clear. A role-played figure is a figure that provides the client's wished-for interaction to replace responses of the old map. We cannot change the past, but clients in a PBSP structure can experience what it might have been like to interact with a more positive character in the original past event. The following rules are followed by group members:

1. Group members can always turn down a role.
2. Group members are not asked to be the figure, but only to role-play the figure.
3. Role-play figures are instructed what to say in that role, how to say it, how to move, where to be in the room and not to deviate from what they are told.

4. Role-played figures need to understand the importance of placement. Spatial characteristics are as important as emotional characteristics.
5. Role-play figures do not use their personality but the personality of the relative in the client's mind
6. Role-played figures do not have to find inside themselves the qualities that the client remembers, but simply repeat in a word for word fashion whatever lines are given them by the therapist.
7. Role-played figures at the end of the structure, make a de-enrolling statement, "I am no longer role-playing the part of your (relative) who had(context); I am ".....(name)". This makes it possible for the person who had the role to drop that identity and leave the structure, no longer a part of that role. Most importantly this helps keep separate and distinct the symbolic in the structure and the literal in real life, so that they are not confused.
8. Improvisation is not allowed. The role-played figures mimic the client's actions, words, feelings, and truths, fully expressing each emotion.

Possibility sphere

In the Possibility sphere the therapist metaphysically surrounds the client with a consciously extended psychological space within which the client can work in safety and hope. When Pesso thinks of the encircling of the possibility sphere and the person within it, he envisions a symbolic uterine environment, in that the uterus provides the developing fetus with whatever materials it needs for self realization. The therapist is like the supporter and protector of the possibility sphere. The therapist listens for the

ideas, values and life strategies that are a part of the negative experiences, such as “You’re no good,” or “The world is no good,” or “Everything is meaningless.” These are noted by the therapist during the structure. Present examples of historic non-connectedness, non-relatedness, meaninglessness, fear of madness and maybe death are also noted, either mentally or out loud during the structure. The therapist is also on the look out for the opposite attitudes which are supportive of a belief in meaning and hope. The positive is exactly the opposite; it says, “You’re good; The world is good; There is hope; There is a way, that leads to connection to the self, connection to others, activity, meaning, hope, and life” (Pesso, 1997, p. 2). The goal is to create an environment that Winnecott’s (1965) *good enough mother* would have created for the child, where she can receive the support, protection, nurturing, and limits missed in her early development.

Micro-Tracking

Fragment figures are the witness figures, contact figures, limiting figures, understanding figures and many other figures. Fragment figures also include a variety of voices such as voice of truth, voice of discounting, voice of reasonableness.

The role of the witness figure is to see and identify current feelings that are on going in the here and now of the structure as put forth in micro-movements of the body and face of the client. The witness figure continues to track the client and capture the present moment throughout the structure. This process enhances clients capacity for self-observation, his feelings of being attended to, listened to, and understood and brings about an element of security. Typical witness figure statements speak words such as: “A witness would say, how crushed you feel when you believe that you’re not important enough to be heard.” Another witnessing statement might be, "I see how angry you feel as you hear that statement." When there is an affect that will put forward a witness you

would organize based on the verbal context that the client is presenting. “I see how angry you feel as you remember (“whatever event they are describing that is producing that feeling”).

The witnessing procedure provides the client with a role model of self-observation that enhances the client’s prefrontal cortex’s capacity to oversee and modify the emotional limbic system. Since the right brain is more involved in preserving a connected sense of oneself (Devinsky, 2000), the therapist offering of the witness procedure enhances the clients fundamental right brain characteristics of self awareness, empathy, and identification with others. This aligns with Fonagy’s belief (1999) that the heart of therapy for trauma clients is teaching them the reflective process.

The witness figure offers the basic elements necessary for secure attachment as defined by Siegel and Solomon: contingent communication, reflective dialogue, emotional communication, and the coherent narrative. By mirroring and reflecting the client through the witness figure, the therapist helps the client organize and view her thoughts and emotions in tandem. This also promotes neural integration by encouraging a simultaneous attendance to both parts of the brain (Siegel and Solomon, 2003).

The fragment figures, or “voices”, are role-played figures who speak the client’s own thoughts, reflecting his or her negative or positive inner attitudes and values which have been accumulated as if they were fundamental truths. A role-played voice of truth figure states for the client thoughts and beliefs that the client has lived by as truth. For instance, if the client says, "I have to take care of myself because there is no one in the world who will do that for me," the truth-stating figure is instructed to speak that truth by saying:

"You have to take care of yourself because there is no one in the world who will do that for you."

Another voice is the voice of negative prediction, such as, You're going to do it wrong. The voice of strategy outlines a method of behavior designed to attain a certain end goal, for example, If you do this, such and such will happen. Other voices are the voice of warning, the voice of doom, the voice of discounting. The voice of reasonableness usually dampens down one's feelings of disadvantage, unfairness in history, or pain. The voice of survival tells the individual how to survive in a problematic world.

PBSP structures use ideal figures to provide the client with tactile, visual and auditory input that helps them construct in the mind and in the body an experience similar to the original traumatic event. While clients are role playing the situations and vividly remembering past events, ideal parents can be enrolled. These parents are role played by others to provide a corrective, positive experience in the event that is remembered.

Ideal figures are new people created by the client to meet the client's wants and needs, providing the healthy attachment that Bowlby, Ainsworth, Main, and Solomon describe. Although the activity occurs in the room, the most meaningful part of reframing the original traumatic event occurs in the client's mind. With the therapist's help, this therapeutic experience is carefully linked to childhood memories. The result of a successful structure is the client believing and anticipating a new and more satisfying future. These ideal figures help the client create new symbolic self objects to lessen the impact of the negative self objects.

The *entity* is the split off, omnipotent part of the client that resulted from a deficit of external figures powerful and stable enough to help orient the client. The entity part works against losing power and authority and does not necessarily want a good *end*. This is where Pesso stops, identifies the entity part, and asks the client if he can make a contract with the part of the soul that wants to change and have a good end. According to Mahler (Crain, 2000) this is helpful for the client who has experienced disorganized attachment, and has no safe winning options. The client's defensive structure for regulating her affect has been approach/ avoidance. When there is no love aspects internalized, the child creates defensive splitting in order to cope with the frustration and loss. The contract offers her a winning option for separation. Mahler says the most important outcome of the separation-individuation process is to internalize a positive self-image and positive relationships with external objects (Crain, 2000). Together these enable the child to maintain self-identity within relationships.

Setting up the True Scene

The true scene shows the truth of the client in the present, that very moment in therapy. The true scene cannot be planned. "For the true scene the therapist asks, 'What are you feeling now in your body, what is in the foreground of your mind?' We assume this particular *now* will contain all the learned meaning of past situations, both good and bad" (Pesso, 1991, p. 54).

In the True Scene, the client's actual feelings at that moment are highlighted and externalized by the witnessing figures. In this way, the therapist helps the client become more aware of his body sensations (What are you feeling in your body?), and access current thoughts (what are you thinking in your mind?). In the True Scene the client is in touch with all of the parts of himself that have been mirrored to him by his parents.

Via micro-tracking the therapist uses the witness figure and voices to provide the client with verbal information about any affective states (especially facial expressions) or cognitive beliefs that are expressed. Expressions of the body and mind are often considered together. By asking the above questions, the therapist invites the client to access basic truths and feeling states that the client has learned for survival in the world (Pesso, 2002). This leads to the remembrance of underlying scenes and events which relate to and are the foundation of the present state of consciousness. Present perception of life is directed and driven by memory. Past traumatic events produce thoughts and emotions that can be redirected in what is called the Antidote Scene where new healing memories are created. The antidote scene is part of a structure that offers the client the new needed reconstruction of the old memory. These new implanted memories become integrated as if they were actual history, and thereby, improve the client's life.

In the true scene, the therapist may ask, "Is this a familiar pattern?" to help the client link current life events with past life-shaping events that have a similar emotional and cognitive affect. Historical scenes pop out of these recollections and evoke powerful memories that are externalized in the room by the therapists. Thus, in a structure the client is able to re-live a vivid memory, (the there and then) while at the same time observing him or herself from (the here and now). They are now in the Historical Scene (the there and then).

Setting up the Historical Scene

The feelings surfaced in the True Scene help lead the client to recall the original hurts and traumas of the historical experience. "The intention here is to externalize the images that are seen in the mind's eye in the interior theater of memory and imagination and have those scenes and figures represented in the room" (Pesso, 2003). Pesso instructs

the therapist to *capture* these historical experiences by enrolling them as symbolic objects or role-playing figures, so what is in the mind's eye is replicated in the room. Even though the client is absorbed with this externally represented memory, he or she is still able to use his or her new-found awareness of emotions, body sensations, and impulses to express what is coming up from moment to moment in the present. The therapist is looking at what type of past history is afflicting the client's present in a negative way. Pesso identifies three different kinds of historical scenes, which he labels Tier 1, Tier 2 and Tier 3.

In Tier 1 the client has suffered deficits of her basic developmental needs as a result of uncaring or unable caregivers, causing negative consequences on her normal maturational processes. The usual intervention in this case is to supply her with ideal parents who can capably meet her needs. Each event that highlighted a deficit is replayed and satisfied/solved both verbally and non-verbally.

At the end of such a structure we help the client anchor and imprint this symbolic/virtual event in what we call the mind's body – a repository of remembered age states, actions, and interactions that are the data base out of which people construct future anticipations of interactions in the real world (Pesso, 2003).

In Tier 2, the client has suffered from abuse and experiences unbound aggression, love, and sexuality. The healing interventions needed are the genetic natural needs for protection, limits and bounding. Bounding is another word for placing limits on drives that have never been ego-wrapped. When a child is abused, they often will experience too much flooding of feelings and sensations. This intensity overwhelms the child and goes beyond their ego's ability to sustain and contain the energy. The client needs to experience limits and bounding in these overloaded areas. The ego skin that covers the ego is ruptured and the ego can't contain the feelings. When the client experiences in the

body over arousal, fear, and rage, the body becomes an enemy. Now danger is inside the body with no safe haven; this leads to dissociation. The abuse blows away fairness, meaning, ownership, and trust in the body.

In Tier 3 the historic scene is where the child filled the roles of inadequate caretakers, thereby creating the need for closure in our ancestry. “The client’s innate capacity for compassion has been too early awakened and over-stimulated by the sight of suffering loved-ones, so they meet the caretaker’s needs even in their own mind’s eye. The consequences of this are deep, dark and disastrous to her natural inclination because it interrupts the stage of learning to take care of her own self interest. This kind of history is the foundation of a life-long pattern of attending to the needs of others at the expense of neglecting one’s own needs” (Pesso, 2003). Attending to other’s needs has two origins:

1. The innate drive propelled by the child’s compassion to alleviate the pain of the parent’s suffering
2. The belief that filling these “holes in the roles” that the parents will be able to parent them.

The healing intervention is *Holes in Roles*. When in Tier 1 historical scene, the possibility of ideal parents doesn’t seem believable, it means that the client is still taking care of parents. At this point, the therapist may ask the client who is the client taking care of in the family’s history. Another way of finding the holes is asking the client, “What are some stories they have heard about past generations, for example, grandparents, aunts, uncles, or other relatives.?” A child not only hears the stories but simultaneously sees those stories in his mind’s eye. A client innately knows who the relational figures should be in order to satisfy those needs in his personal stories. The

intervention involves releasing the client from the burdensome task of filling in holes in roles by going back in time and creating a memory of past generations receiving the place, nurture, support, protection or limits not provided to them. “This step fulfills the innate wish and expectation embedded in everyone’s soul for a gestalt, closure and completion in the family network”. (Pesso, 2004) Amazingly, after this intervention is completed, the client is able to go back to Tier 1 and receive his own symbolic place, nurture, support, protection and limits.

Setting up the symbolic healing scene (new map/antidote)

In the symbolic healing scene, the client experiences an alternative possibility that will counteract the impact of his original negative experience. Another way to describe this process is to call it a creation of a new map, which provides more responses than the old map. This allows the old map—old ways of coping, old negative images, and inappropriate responses—to surface. It also stimulates the creation of a new map, which provides alternative, positive images and more appropriate responses. The role-playing figures represent parts of the original figures and assist the client to verbally and physically access and express what was not expressed in the original event.

Accommodation is the role-playing procedure that guarantees that the client’s wished-for interaction or experience to replace responses of the old map. The accommodation is the countershape procedure that describes the satisfying behavior of the ideal figures. While emotional expression is important output, it does not bring lasting change without the input of new experience. We cannot change the past, but clients in a PBSP structure can experience what it might have been like to have had a non-rejecting, more positive character in the original event.

In conclusion, by creating new and positive attachment experiences and promoting neural integration, the structure experience gives clients a positive perspective in which to view and experience the world, complimenting their other therapeutic interventions and integrating the somatic processing with cognitive and emotional processing. When successful, the positive attachment experienced in the structure helps the client to internalize a new experience of growing up in a loving environment represented in both mind and body, and to change avoidance or fear of relationships into hunger for healthy relationships. Clients are no longer so controlled by anger, anxiety, depression and craziness, thus enabling them to tap into their innate sense of hope and peace in everyday settings.

Chapter VI: Case Study

PBSP training is a four-year process. After I experienced the first introductory training week, I was so taken with the work, that I began to implement it immediately. Please keep in mind my training status as you read the case study using the PBSP method.

J. is a 27 year old, Caucasian female, referred for concerns of her emotional and physical well-being. J. appears to be very energetic, outgoing, and personable. She dresses very hip and wears make up. She is currently trying to break out of a life style that includes starring in pornography films and abusing drugs.

She has expressed a longing to retrieve her self-worth. She struggles with self-doubt, anger, interpersonal relationship issues, and self-destructive behavior. She is very aware that her problems stem back to witnessing a bitter divorce between her parents, and then being molested as a child and raped as a teenager. She has a history of smoking and abusing drugs starting at age 12, alcohol, acid and crystal methamphetamine at 14, cocaine at 15, and participating in pornographic videos starting at age 20.

J. has never been married. She has one younger brother. Her father and mother argued vehemently and divorced when she was six. Lieberman (1993) outlines several emotional problems common to children of divorce. J. experienced many of these. Grief and anger are an unfailing outcome of any type of loss, including loss of family through divorce. Parents are usually immersed in their own emotions, and not equipped at the time to support the child's needs. Leaving and reuniting with parents is often troublesome for children even in a stable environment. When the environment is strained, and the child must choose one parent and then the other, the effect on the child can be traumatic.

When J. was eight, she was left alone with the father of a friend of her family. He took her to the library and molested her there. This happened on two occasions. She feels guilty for liking it, even though she knew it was dirty and wrong. The family friend was notified but charges were never pressed and later it was discovered that he molested other children. At age twelve, J. started taking drugs. And at age fifteen, she was date raped, and again at age nineteen. She reported the date rape at nineteen but there was not enough evidence to convict.

She is self-critical and this seems to have caused a lot of anxiety about what she is responsible for and what she is not. Part of her seems to want to vent her feelings while the self critical part of her will not allow this behavior to come forward. This strong defensive structure has given her a way to avoid dealing with her deep emotional hurt and has also helped her to survive.

The client's aggressive tendencies have contributed to turning her anger about situations and people outward, instead of finding a proper channel to vent these feelings and talk them through to resolution. The tremendously sad emotion she feels and experiences when hearing other people's pain may be ways in which she is feeling her own past pain.

J. began group therapy and moved fairly quickly into a trusting posture. This tendency to trust quickly may work for her, not against her in this group. She frequently shows up at group with bruises on her body from drinking and falling down. She sometimes seems to put on a façade of giddiness when telling us these stories, contradicting what she is actually feeling. This façade can give the illusion that she is doing well when she is actually having a difficult time.

J. is in one-on-one counseling and group therapy. When treating the trauma patient, it is imperative that the therapist provides more than one modality. APA Guidelines suggest multiple interventions combining different therapeutic approaches. (Shore, 2002). For the purpose of this paper, only the modality of PBSP in a group setting will be described and not the one on one therapy.

Case Structure 1

J. volunteers to do her first structure. J. describes her desire to stop her self-destructive behaviors. She moves to the center of the room and describes to us how she fell in a parking lot and down the stairs the night before from drinking too much. This was after four continuous nights of drinking. She counted for us the nine bruises on her body.

True scene.

Therapist (T): Would you like to enroll someone or something as the part of yourself that hurts yourself?

J: (points to the biggest object in the room, an eight-foot ficus tree in the corner. She gets up, walks over to the ficus and drags it to herself and places it right next to her and calls it her “sidekick”.) This keeps me company, kept me safe my whole life. I’m always in charge of this and I know exactly what will happen. (She calls it “Destruction”. She smiles and looks pleased.)

Witness (W): You look real pleased you have something to count on and keep you safe.

J: I always knew it; I feel safe.

W: A Witness would see on your face how delighted you look having this close to you.

Historical scene.

J: (nods her head and says, she feels safer with “Destruction”.) No one protected me, so I needed to do it. I can protect myself from danger. I invite it in. Instead of it coming to get me, I go get it. I’m in charge of it. (She smiled and felt her power over the danger.)

W: A Witness would see how powerful you felt controlling the danger.

J: Yes.

T: Ah, I see that you’re smiling about this. Let’s name this power the entity. I would like to make a contract with the part of you that wants a good ending. Your soul that wants a good ending.

J: I was the only one that could protect me, no one else could.

T: Let’s enroll the no one else part.

J: I came to a really lonely place one night in my Hotel room. I didn’t understand why, I thought I had everything.

W: A Witness can see how sad you felt that no one was there for you.

T: Let’s enroll the no one else. What would serve this no one part.

J: The void. (stands up and walks over to the shelf, picks up a flashlight and enrolls the flashlight to play the void.)

T: (observes that this is the first time J. has seen the role that danger has played in her life.) This place looks like a love relationship. (Sees that she felt how it had parented her, the good mother and father, she got clarity that she was in control of it)

J: All I've known is danger; this is my friend, all I've known. (She pulls the ficus plant closer to her.)

W: A Witness would see how satisfied you look with it next to you. How certain and resolved that you have this in your life.

T: (observes that the tree is symbolic of how big the destructive piece in her is; it is the most powerful piece of her. She was so impressed with the width, size, and branches. This really brought clarity and some sobriety. It helped her see how big the destructive piece is.)

Case Structure 2

J. starts to describe her boyfriend whom she has known less than 2 weeks and how invested she is in him. She believes he is how she will get well. I feel uncomfortable and many group members feel uncomfortable with how much of her sense of well being she has now invested in her boyfriend, her whole life. I sense some danger there. She continues to describe how he is the way and will show her the way to her happiness.

T: Oh, this boyfriend is going to be your ticket to well being and safety from danger. I don't know about this. I am uncomfortable with how much of your well-being you have invested in him. (We had her enroll herself a safety figure.) How are you going to get to Safety?

J: I will use the boyfriend.

True scene.

As in the structure three months previous, J. puts the "destruction" (large ficus tree) next to her and she says she is carrying the "destruction" with her. She also describes an emptiness she feels inside her. She chooses a flashlight to represent the sense of a void she has inside.

She positions a chair opposite her on the other side of the room and names the chair (safety, protection, healing) She enrolls the chair as protector part of herself. Between her and the chair is a Globe enrolled as her new boyfriend and a flashlight enrolled as the void. Then she sits with the ficus tree enrolled as the entity she is bonded to.

Historical scene.

J: (looks at the enrolled object of her boyfriend) I would rather the boyfriend be behind the protector chair waiting for me. Somehow I have to get to the chair on my own. I don't think the boyfriend can get me there to safety. I need to get rid of the void and the entity. The boyfriend built the bridge there, showed me how.

W: A witness would say you are looking inside to see what you need. You look sobered by the thought that your boyfriend can't do this. You look puzzled at trying to figure out how to get there.

J: My boyfriend shows me how, I asked him to show me how. I asked him to stop me from drinking and smoking. He gets mad when I ask him to do this and won't talk to me.

W: You liked that feeling of him protecting you.

J: He shouldn't have to.

T: If he shouldn't have to how will you do that?

J: (kicks the void. (Flashlight).)

W: A witness would say it feels really good to you to kick the void.

J: I could kick the "destruction", but it won't go away.

T: It makes you feel your smallness. You look certain it is bigger than you.

W: A witness would say how absurd it is to you to imagine anything without "destruction." You look certain of your need for it.

J: I need to get rid of void and "Destruction". Boyfriend built the bridge for me. Showed me how I have to do it. "Destruction" f__ed up babysitting. It was all because of that bad babysitter. (Referring to her molest by her mother's best friend's father) Taught me all the bad things.

Symbolic healing scene.

T: The "Destruction" was what you needed. Would you like ideal parents? An ideal mom and dad to take you to the safety place.

J: (drags the "Destruction" (8 foot ficus tree) back into the corner of the room) I don't want to need it. (She turns to the ideal dad and mom) Come stay next to me. I want the ideal mom and the ideal dad. (She wants them to say the "Destruction" is gone and she won't have to deal with it.)

IP (Ideal Parents): As your ideal parents, we will stand by you, the "Destruction" is gone and you will no longer have to deal with it

W: A witness would say, I can see this brings up grief in you.

J: No, not grief.

W: A witness would say the tears are relief. You feel relief that they can manage the "Destruction."

J: yes!!

IP: We are big enough to manage the "Destruction".

W: A Witness would see how much relief and how happy you look.

J: It feels good to have the entity and void behind me. It feels good to have the ideal parents flanking me on both sides. This is the feeling it should have been. I want the ideal parents to walk me to protection. They are giving me foundation and strength to be my own parent.

W: A witness would see how settled you look and how right it feels. The rightness of your parents flanking you side by side.

J: They can release me and go back now.

IP: As your ideal parents, we have given the foundation for you to be your own real parent.

T: Is that good?

W: A witness would say you would feel that is right and that is what the ideal parents would give you.

J: (nods and asks for a hug.)

T: Ideal parents can hug you and go back.

W: A witness would see how thoughtful you feel.

J: I feel overwhelmed.

T: How much this meets that place in you.

W: A witness would say how soothed you feel in the place of being protected by parents.

J: I feel such a relief.

W: A witness would say what a wonder it feels to feel a place you never thought you get to.

J: I thought the entity and void had to be around.

W: A witness would say how surprised you are.

J: I feel comfort and strength.

W: A witness would say how good it feels to feel comfort and strength separate from the entity and void.

J: I want to shout!

W: A witness would say I see what incredible joy you feel!

J: I am free. I am not dragging anything. I am free.

W: A witness would see how much joy and happiness you feel and how proud you are.

J: That is something I always needed.

Case Structure 3

About 4 months later J. volunteers to do a structure around her inability to give up smoking cigarettes. She was diagnosed last month as having a pulmonary heart disorder. Her lungs look like the lungs of a 60-year-old woman. Even though she has been at the emergency room twice now, the last time for severe pain in her heart, she cannot give up smoking. She is frightened of this dilemma.

True scene.

J: (enrolls her cigarette lighter to be her cigarettes. She lays the lighter on the ground in front of her.)

T: What does the cigarette give you?

J: The cigarette says, "I'm going to comfort you. I'm going to relieve you. I'm going to calm you."

T: Is there anything else?

J: The cigarette says, "I give you enjoyment, secrecy and pleasure in private." When I smoke, I feel like I'm in high school again, sneaking off.

W: A witness would say how exciting and energizing to feel like your back in highschool, sneaking off to smoke.

J: I know I'm not supposed to do it but I'm technically not doing something bad. I'm not supposed to, it's not illegal and socially acceptable.

W: A witness would say there is a sense of pleasure at getting away with it, tantalizing.

J: I sense a pleasure of getting away with it. Wonderful! This makes me smile and want to hold on.

W: A witness would say, you look intrigued at the thought that you sense a pleasure from getting away with it.

Historical scene.

J: I've been smoking for 15 years. Cigarettes have comforted me like a Teddy bear and blanket. Cigarettes have been my comfort. They never let me down. One consistent friend.

T: How faithful this one consistent friend.

J: Cigarettes never talk back they are there always to comfort me. I feel a tinge of sadness that I had to turn to cigarettes.

W: A witness could see a tinge of sentiment, sadness at how you have had to rely on cigarettes for comfort.

J: They were consistently reliable when I needed it. The cigarettes are a source of consistent comfort. Always handy. Always there. Never bad to me.

T: This was the one consistent, reliable always comforting presence.

J: If I was happy or sad, they were there.

T: You could have them there in a moment, instantaneous.

J: But ultimately they betrayed me. Like everything else, eventually I couldn't count on them but I never expected cigarettes to betray me. I know I have to let go. I never felt it would leave me at such an early age. Betrayed. Two packs a week. I keep pushing the limit. This is the last one. O.K. J., this is the last pack, give them away. I wish I had just one more.

T: What happens with one more time?

J: Anxiety and comfort.

T: It feels something like the one more will offer you something. What is the (internalized) part that allows you to push the limits?

J: Dangerous game I play. This part feels like danger and fulfillment, we can push it one more time. It will feel good but it will hurt. I call this part *miserable comfort*. Just like my ex-boyfriend "Chuck" and Jack Daniels.

W: A witness would say you look intrigued at how danger and comfort accompany one another.

J: When someone hurts me, I always go back one more time. Just like my friend Chuck and Jack Daniels. I always want to go back and end it on my terms. Now a dangerous game I'm playing. (Points at cigarettes.) On your terms. I don't want to let it go. I'm not ready to let go. Just one more, but it can never be just one more.

T: You want to keep the smoking as a comfort. It hurts you, but it's always been there.

J: Like everything in my life, a *miserable comfort*." I don't know anything different. Like food, everything is good and bad for me. Work is a miserable comfort.

W: A witness would see how surprised you look at the familiarity of hurts and comfort all at once.

J: Everything in my life is a miserable comfort. This is absolutely foundational! Miserable Comfort.

T: This has been foundational, how you have counted on solidity of this miserable comfort.

Continuation of Case Structure 3

We continued the case structure the following week.

True scene.

J: (Enrolls the cigarette lighter as a cigarette) I enroll you as a cigarette; you are no longer a cigarette lighter. (She places it in her hand) So, this morning I panicked and had a cigarette. I smoke when I drive or when I'm bored, I will sneak one at work. I also smoke when I panic and need to calm down. Refreshment. Excitement.

T: I hear that cigarettes provide refreshment and excitement.

J: Miserable comfort from cigarette.

W: A witness would see how intrigued you are by the idea how present miserable comfort is in your life.

Historical scene.

J: Everything in life is miserable comfort. Little girl in me wants comfort. Since molestation, everything is miserable comfort.

J: My parents feel guilty. I've played upon their guilt. They didn't realize the ramifications of the molestation. No one had the strength to deal with it at the time.

W: A witness would see how clear and certain you are about what their limits were.

W: A witness would say how sad you feel about how far down this road took you.

J: Not sad, spiral of events, no one came in and helped, No one came in and said, "stop".

T: Parent's didn't say, "stop", lets place them in the room somewhere.

J: (She enrolls parents to assist in the structure and picks out two pinecones as real parents) They didn't know how to help me, so now I smoke. All the comfort came from the drugs and drink and cigarettes. Cigarettes are not serving the purpose.

W: A Witness would say when you look at the pinecones you feel sad because there is no comfort coming from them. They're not telling you to stop.

T: I notice your hands are holding the cigarette tighter.

J: Holding on for dear life!

T: Do you want to enroll someone to be the protective voice that says, "stop"?

J: I don't want a human enrolled to say, "stop".

W: A witness would say you look stoic and detached.

J: I'm finding comfort in being stoic? Painful process. Not afraid. I prided myself on not being afraid. I hate that word. I'm not afraid of anything- like my parents. Brings my soul miserable comfort.

W: A witness would see a smile around the idea "I won't be afraid".

T: Entity gets something from this. Entity might say I will never be afraid.

Symbolic healing scene.

J: (enrolls a group member as a trusted figure-comfort contact figure or ideal trusted friend)

W: A witness would see how comforting that looks. And it also brings up grief to sit in the presence of a comforting figure.

J: It is happy grief. With comfort contact figure I can tell I wouldn't need cigarettes so much. I have relief from having someone to trust.

T: Oh, this is good comfort; it brings happy grief, not the miserable comfort. Notice how your hands have loosened up on your lap.

J: I let go of all the other self-destructive things in my life; I'm just holding on to this last one.

T: What would you need from your comfort contact person at this moment?

J: I don't know how to let go.

T: What would a trusted friend say?

J: Deep down I do want to let go. It hurts my health. A trusted friend would say, "I won't be around you when you smoke."

T: Lets put the voice of truth out into the room.

J: I want the fichus tree to be the voice of truth. (Previously she had enrolled the fichus tree as the "Destruction")

T: You want the tree to represent something good for you.

W: A witness would say you look satisfied that the tree wants something good for you today.

W: A witness would see your soul is pleased to move on from destruction.

J: I want to step on cigarette, to stomp on it. I want to drop it off the side of the building. (She puts the pinecones and lighter under her cushion and sits on them. J smiles.) "All Gone. All gone...All gone.... I am damned pleased. I feel grief. It's taken me a long time to get to this place; I've been working on this piece since I was 7 years old. I didn't know I could have idealized parents. The ideal parents in my head say, "We love you. We support you, you are going to make it thru this".

T: It would be good for you to enroll the ideal parents outside of you so you can hear it come in from the outside. You had to parent yourself for so many years.

J: (enrolls two group members, one as ideal father and one as ideal mother, and tells them what to say)

IP: We love you, we support you, and we will get through this. It's ok; we're here for you. We support you. We're going to give you what you need to get through this.

J: The ideal mother outside of myself is less impacting. I don't know how to put it in words. It seems fake outside of me.

T: I am struck at how you are sitting on the pillow with the yuck underneath you, still doing the nesting.

J: I do it all myself and don't want to. I am sitting on everybody else's shit. My soul feels as if I am taking care of myself finally. I am angry with parents. (Crosses her arms across her chest)

W: The witness says, I see how angry you are for having to do it all by yourself..

J: Yeah! I'm angry with them! I don't want to sit on them. I want to stomp on them and disobey them and get over it. No, I don't want to be angry.

T: But you are angry.

J: I am angry. All this could have been avoided. Ideal parents would have dealt with this differently. (She tells ideal parents what to say)

IP: We would never have let it get this bad. We would never have let you smoke in the first place.

J: What parents would have allowed a child to smoke at 12? Disgusting. I would not let a child smoke at 12!!!!!!

IP: We would never have let you smoke at 12. We would never have allowed you to smoke at all.

J: I would have put the f__ing molester in jail.

IP: We would have put the f__ing molester in jail. We would of never left you alone with him. And we would not have let you smoke at 12. We would have been around to watch you and to comfort you.

J: I feel such a realization of what I grew up with. How early I became an adult. I would have loved to have been a child.

IP: We would have allowed you to be a child. We would of dealt with everything.

J: Ultimately I know what I need to do. I know what the words of the ideal parent are in my head. I need to comfort my little girl inside of me.

IP: We would of comforted you so you wouldn't have too.

J: I can't be sad about this. My heart really hurts. I feel grief. My real parents know they didn't protect me. They can't make it right and can't change it. They honestly didn't know any better.

J: My innocence was lost by my molester. I brought in cigarettes to parent and comfort me. Cigarettes brought miserable comfort.

W: How grievous you feel at the loss of your innocence and how you brought in comfort to yourself.

J: I feel grief at the loss of my innocence, lost sense of self-confidence and self worth. It hurts that someone could have taken it from me. Those parents didn't protect me there or any other aspect of my life.

T: What does your soul need right now?

J: It's okay; I'm getting through it. It's nice I have people around me to get through it. It's comforting that they know it's happening. It's not a bad sad; it's a *good* clarity piece. It's the first time I've felt a good clear sense of the sad, separate from misery. It's a separate sense of the sad. I don't want to let go of the sadness. I want to feel the sadness of the molest. My trusted friend can provide me a sense of comfort. (She leans her head on her enrolled trusted friend)

Conclusion

The above case study illustrates the effectiveness of PBSP structures in treating a trauma client. A variety of interventions were used in J.'s therapy. In her particular case, PBSP was an effective part of her treatment because it allowed her to increase her awareness of her self-destructive part. She was also able to separate out her sadness from the miserable comfort. She is now a manager of a small business, attending junior college, and is in a committed relationship. While she may still be symptomatic, she was able to explore her traumatic childhood, and begin to experience recovery and a less self-destructive lifestyle. She also was able to develop her own more congruent autobiographical narrative with the eyes of the many group members witnessing her story.

The ideal parents in her structure were able to give her the much needed focus on her subjective experience for the development of her well-being. This intervention demonstrates how someone can change the neurochemistry in her brain through these structures and how the client's ability to tell her story in a meaningful and understandable way impacts her life today. J. was able to take more ownership and power over her life, integrating new information into her brain, and opening herself up to more satisfying connections with herself and others.

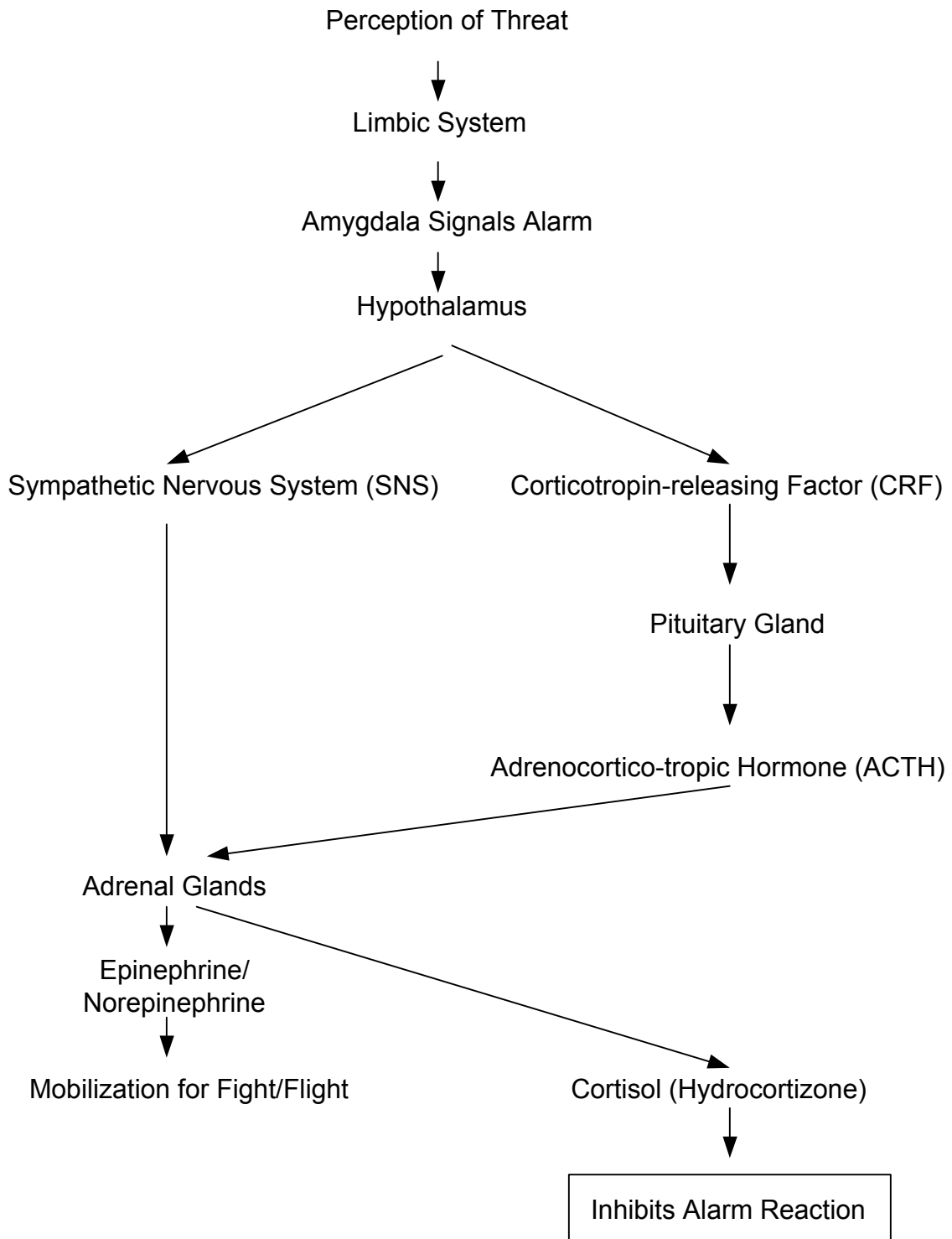
As seen in J.'s structure, she deeply held on to the one piece that reminded her of her unresolved grief, which she called *destruction*, which was more familiar and safe to her than healthy connections. Because of her disorganized attachment, pulling the destruction to her might provide a solution to approaching the frightening caregiver object. That moved her to a place of awareness of what a healthy connection could be like.

Internalizing the resources of a healthy ideal parent-child relationship better enabled her to respond to and react to the world around her, and helped her begin to replace the internalized bad self- image. With the ideal parent enrolled, she could rely less on the internalization of the bad and abusive relationships. The positive attachment experienced in the structure helped J. to internalize a new representation of a caring relationship in both mind and body, and change avoidance and fear of relationships into hunger for healthy relationships. By creating new and positive attachment experiences and promoting neural integration, the structure experience provided J. with a positive perspective in which to view and experience the world. She now has more tools to help her choose not to be controlled by anger, anxiety, depression, and craziness.

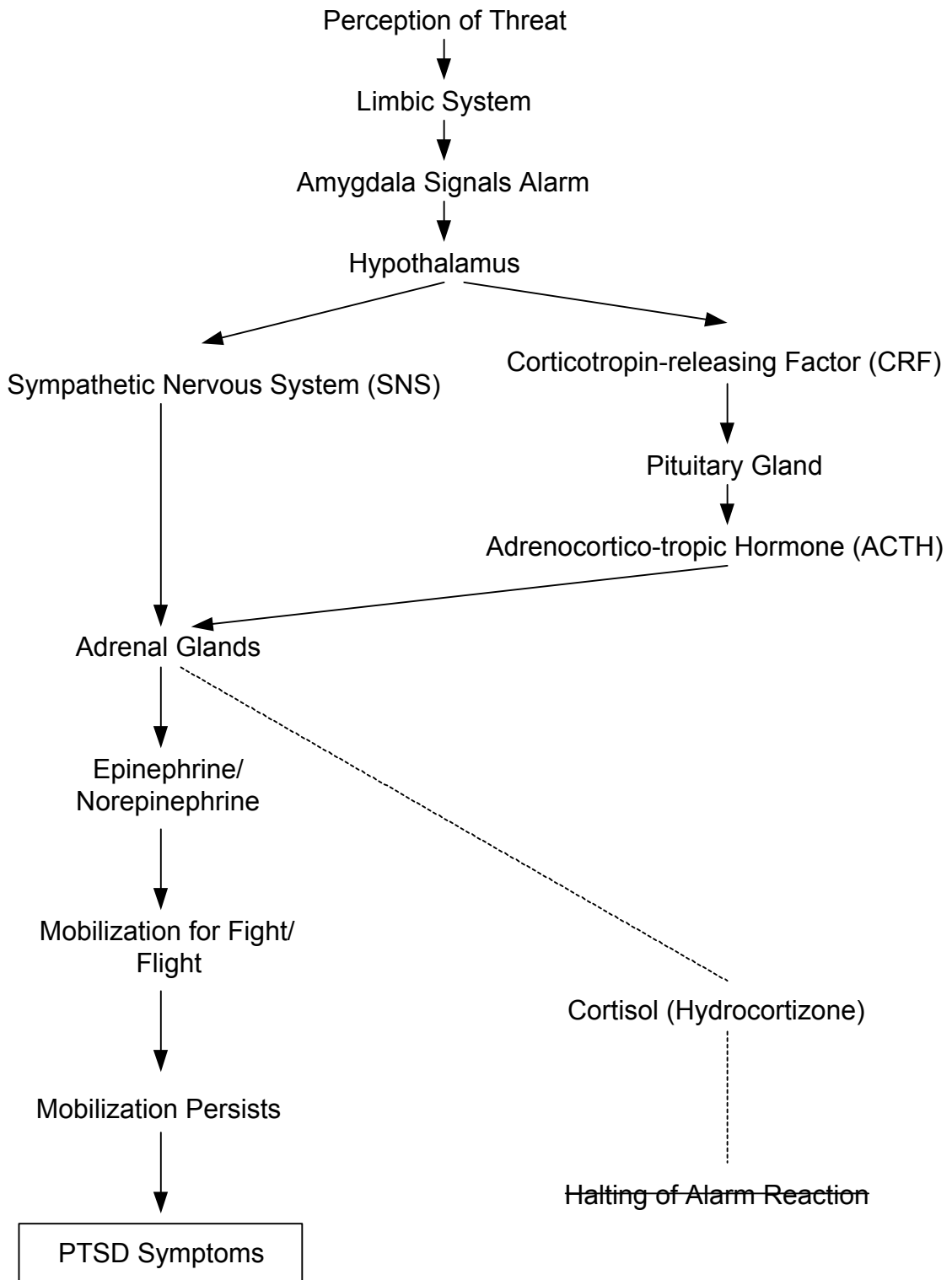
Appendix A: Complex Post-Traumatic Stress Disorder

1. A history of subjection to totalitarian control over a prolonged period (months to years). Examples include hostages, prisoners of war, concentration-camp survivors, and survivors of some religious cults. Examples also include those subjected to totalitarian systems in sexual and domestic life, including survivors of domestic battering, childhood physical or sexual abuse, and organized sexual exploitation.
2. Alterations in affect regulation, including
 - Persistent dysphoria
 - Chronic suicidal preoccupation
 - Self-injury
 - Explosive or extremely inhibited anger (may alternate)
 - Compulsive or extremely inhibited sexuality (may alternate)
3. Alterations in consciousness, including
 - Amnesia or hypermnesia for traumatic events
 - Transient dissociative episodes
 - Depersonalization/derealization
 - Reliving experiences, either in the form of intrusive post-traumatic stress disorder symptoms or in the form of ruminative preoccupation
4. Alterations in self-perception, including
 - Sense of helplessness or paralysis of initiative
 - Shame, guilt, and self-blame
 - Sense of defilement or stigma
 - Sense of complete difference from others (may include sense of specialness, utter aloneness, belief no other person can understand, or nonhuman identity)
5. Alterations in perception of perpetrator, including
 - Preoccupation with relationship with perpetrator (includes preoccupation with revenge)
 - Unrealistic attribution of total power to perpetrator (caution: victim's assessment of power realities may be more realistic than clinician's)
 - Idealization or paradoxical gratitude
 - Sense of special or supernatural relationship
 - Acceptance of belief system or rationalizations of perpetrator
6. Alterations in relations with others, including
 - Isolation and withdrawal
 - Disruption in intimate relationships
 - Repeated search for rescuer (may alternate with isolation and withdrawal)
 - Persistent distrust
 - Repeated failures of self-protection
7. Alterations in systems of meaning
 - Loss of sustaining faith
 - Sense of hopelessness and despair (Herman, 1997, p.121)

Appendix B: Normal Response to Threat



Appendix C: PTSD Response



Appendix D: Personal Meaning

My desire to study attachment theory/object relations, the brain and how it integrates with body psychotherapy gradually evolved from my clinical and personal experiences. In my own therapeutic experiences dealing with pre-verbal trauma, I have sought recovery utilizing a variety of therapeutic interventions and approaches. Because I was traumatized physically pre-verbally, I have found it to be essential to use the following entry points for healing: feelings, bodily sensations, symbols, memories and dreams. As I more deeply explored these with body psychotherapy and other therapeutic forms, I found more relief from anxiety on a deeper level. Unhealthy patterns began to change and transformation began to occur in ways I never imagined.

As a child I suffered from very bad night terrors. When my needs as a child in the areas of physical safety were not met, I grew terrified. Because some of my family members were not able to contain themselves, I never felt my body was safe, with them or anyone. I developed deep-rooted fears, expressed most prominently as social phobia. I needed to put my terror somewhere, and projected it onto objects in my room at night. Many nights my room became a horror movie. I frequently went to school tired. I was expending so much energy at night that I had a hard time with tasks at school during the day; I was exhausted.

As an adult, I knew I had a cry in me that needed to be unleashed, met, and heard. I was wearing a tooth guard at night for clenching my teeth, which I believe, was a physical symptom from the anxiety and fear I held in my body. I was working with a body psychotherapist and in the process of getting in touch with this part of me; she recommended I join a group that used the PBSP methods and theories. By using the PBSP method, I was able to re-create the memory of the original unmet need but this

time experiencing the safety and comfort missing from my past. The therapist allowed me to experience a deep embodied sobbing, releasing the painful memory of terror, and then she allowed me to recreate the interaction that I so longed for as a little girl at night in my bedroom. I am eternally grateful to these therapists that allowed my body to be part of the therapeutic healing process. I have never since needed a tooth guard at night. It is my firm conviction that trauma therapists will deliver more satisfying outcomes if they utilize the somatic features found in the PBSP method when working with clients who have experience with repeated trauma and engage in self-destructive patterns. These clients need a treatment plan that matches the complexity of their issues in a holistic manner.

Appendix E: Spiritual Meaning

In Romans 15:13 Paul says, “May the God of hope fill you with all joy and peace as you trust in him, so that you may overflow with hope by the power of the Holy Spirit.” I believe God designed us to innately need hope of the future and when we have experienced trauma that hope is derailed.

Proverbs 13:12 states “Hope deferred makes the heart sick, but a longing fulfilled is a tree of life.” According to Pessa (2003), “The felt state of hope is first established in an infant’s physical relationship with its mother who pays attention to the bodily satisfaction of its needs” (p. 2). Hope is the container that the good enough mother provides (Winnicott, 1965, as cited in Pessa, 1991). “Thus, the feeling of hope is reinforced and becomes an expectation about the future as the mother regularly and reliably satisfies those basic needs as they arise. For the infant who does experience trust, the core ego strength is Hope” (Erikson, 1964 and Stern, 1986, as cited in Pessa, 2003). Hope is the expectation that despite frustration, rage, and disappointment, good things will happen in the future.

The child who experiences repetitive trauma does not fully develop through these important stages keeping them from experiencing hope and sustaining relationships. And although the adult may have come to some reasonable rationale about the trauma, the body has not yet made sense of it, and it continues to impact the body. Al Pessa’s treatment modality is based on developing the hope that was shattered or never developed

It is this deeply engrained hope derived from the mother, which sustains a child in times of adversity. If one has been nurtured during their maturational years with a sustaining supply of basic needs, nourishment, shelter, safety and love, the child’s hope

will be sufficiently reinforced and well registered, enabling the child to continue functioning productively, sustained by realistic hope, regardless of outer stress (van der Kolk, McFarlane, & Weisaeth 1996).

Pesso (2003) believes that “in order to have hope, one must have a plentiful supply of memories of past interactive satisfactions upon which to base future anticipations of interactive satisfactions” (p. 2). PBSP treatment creates new memories, and thus hope for the future by providing clients with body-based experiences through a reenactment of a healing hypothetical past.

Paul writes in Hebrews 6:18 of the importance of God’s promises to us as our heavenly parent, and how reinforcing God’s kept promises enables us to “take hold of the hope offered to us [and] be greatly encouraged.” God understands how necessary His character and parenting of us is to our hope. We have this hope as an anchor for the soul, firm and secure.

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