# Treating Trauma Master Series

## Capstone Session

with Ruth Buczynski, PhD;
Ruth Lanius, MD, PhD; Ron Siegel, PsyD; Joan Borysenko, PhD; and Bill O'Hanlon, LMFT

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# Capstone Session

**Dr. Buczynski:** Hello everyone, and welcome to this Capstone Session. We're going to focus on the overall broad view of what we got out of this series – what the takeaways were, and the important themes that came up.

So, let me start the way we have always started – what you what were your biggest takeaways from the series as a whole?

## Building Your 'Tool Kit' for the Treatment of Trauma

"Treating trauma is complicated and requires sophistication."

**Dr. Siegel:** My biggest takeaway is that treating trauma is complicated and requires sophistication on our part. We really need to keep in mind many different things, while having emotional sensitivity and attunement to the person we're working with, as well as sensitivity and attunement to our *own* process during this.

So, some of the things we need to keep in mind . . .

"The neurobiology of trauma is important for helping clients normalize and make sense of their hyperaroused and hypoaroused states."

We need to keep in mind the neurobiology of trauma. That is so important for helping our clients to normalize and make sense both out of their hyperaroused states – where they're overwhelmed with agitation and the like – and their hypoaroused states, where they might be dissociated, depersonalized, having derealization experiences or simply shut down with no body energy.

If we have a sense of the neurobiology and how to communicate that to our clients, we can provide maps for them to help them navigate these clearly difficult waters – so that they're not so alarmed by their experience and so that they don't feel so freakish; so they feel like, *Okay, this makes sense. This is what happens to humans when a human being goes through such an experience*.

That element of bringing in common humanity that comes from understanding the neurobiology is important.

I'm sure we'll dig into the importance of pacing a little bit more because it's *so* essential that we help people enter into the zone or the window of tolerance, *and* that we be careful about not bringing up more material than people have the resources to tolerate.

"The body can be a royal road to the unconscious."

We'll dig into this more because it's probably one of the most important take-home points.

Having the flexibility to work bottom-up or top-down. Throughout this series, we often saw that the body can be a royal road to the unconscious.

The body really can be a vehicle for reintegration *because* trauma is so often stored in the body, and we can access it here and now – through sensations, through postures, through action tendencies and the like.

But that's not enough. We also need the top-down cognitive work – the map-making, the helping people be able to re-story and create a narrative about their experience – while knowing that narrative won't really be coherent and all put together until they've really integrated the whole experience.

Another thing we've got to keep in mind is that this *really* is not "one size fits all." We need a lot of different modalities.

For one person it's going to be yoga, or qigong, or grounding kinds of mindfulness practices; for somebody else, talking therapies – whether it be CBT, or more dynamic, or more systemic therapies. For other people, psychoeducation is going to be the core – just helping them to have a map for their experience.

"We need to be flexible and think of ourselves as having a tool kit from which to draw."

We need to be flexible about this and not think of ourselves as having an orientation but rather think of ourselves as having a tool kit from which to draw.

Of course, the centrality of the relationship in holding people and in healing trauma is recognizing that relationships are what allow us to have resilience. Yet trauma cuts people off from relationships; they become secretive, they feel freakish, they shut down on their emotional life.

Whether it's the therapeutic relationship, or friendships, or intimate relationships, we're going to have to

> "Whether it's the therapeutic relationship, or friendships, or intimate relationships, we're going to have to help people reconstruct those."

help people reconstruct those.

Relationship is closely connected to people's attachment. Trying to help people develop a sense of secure attachment – a sense that *I'm okay; I can tolerate what's coming up*, even if they didn't have that developmentally, which many people did not.

In fact, one of the things we learned is that *that* is one of the predisposing factors to an experience *becoming* traumatic to somebody.

So, whether it's through self-compassion or other practices, how are we going to gradually, within the window of tolerance, help people to do this?

Finally, through all this, our *own* capacity to bear feeling. It's not easy to sit with people who have been traumatized. It's *retraumatizing* to us – or often *traumatizing* to us – to hear these stories.

The takeaway point is it's *hard* to be a trauma therapist. It's *really* hard. There are a lot of things to think about.

> "It's ***hard*** to be a trauma therapist. It's ***really hard.***"

Because it's so hard, we're not always going to get it right; we're going to have a lot of moments where we go too far one way, too far the other way, leave something out, introduce something that's not so helpful. We have to be kind to *ourselves* about this, knowing that this is a vital but also complicated and difficult task we're embarking on.

**Dr. Lanius:** Thanks for that beautiful summary, Ron. I just want to follow up: yes, we *can't* always get it right and we're human. That's also important for our patients to know.

I always think about what Allan Schore talks about – it's so important that we sometimes experience rupture and repair in our relationship, to really build trust.

It's okay to say, "Maybe we went a bit too fast in the other session. What do you think? What do *you* need to feel safer in the session?" Really make it a *collaborative* experience so we can provide what our clients need.

## Working with the Brain-Based Changes That Trauma Can Leave Behind

**Dr. Lanius:** What also stood out to me was that trauma changes the brain, and we now have modalities – for example, neuroimaging – that can really make an invisible injury visible. For our clients, that's *incredibly* important.

So often they've been told, "Oh, it's just in your head – get over it;" but to actually *see,* "Oh, wow – there *is* a brain change that accompanies this trauma." That's really important.

> "Give people hope that they can ***change*** back to a more normal brain functioning after treatment."

The second piece of this is to give people hope that we can also *change* these changes back to a more normal brain functioning after treatment. We have more and more evidence to do this now.

When I think about brain changes in response to trauma, I always think about an adaptive neuroplasticity. Often these brain changes have occurred in order to help the person survive.

We see brain changes associated with emotional detachment that help people to numb out, or that help people to get out of their bodies so that they can tolerate the overwhelming experience and memories.

At the time of the trauma, the brain adapts in a very adaptive manner. It's when we get in the aftermath of trauma that those brain changes can often be difficult. So, to really help people understand *how* those brain changes were adaptive and an adaptive form of *neuroplasticity at the time* of the trauma. And now that they're *out o*f the trauma, we help the brain reshape to suit a safe environment can be really helpful.

> "All the changes we see are very much brain-based and all the treatments that we do really need to think about all three levels of treatment."

I think that was a big take-home session throughout the series: all the changes we see are very much brain-based, and of course that can also very much influence how our body reacts – how our body feels, and how brain, mind and body are connected – and all the treatments that we do really need to think about all three levels of treatment.

And I also *so* agree with you, Ron, about an integrative approach – not getting locked into one school of thought, but to be *open*. These are very complex clients; we need to think about a personalized approach and really tailor the interventions to our clients.

"This is what these sessions have taught us: to think about different approaches and really think about what suits best in each individual case."

We also need to keep in mind that an intervention at point A may not be a good intervention at point B. Different times in therapy can require very different interventions.

Just be open. Not to put down anybody else's treatments, but to be *open* and to really use an integrative approach.

This is what these sessions have taught us: to think about different approaches – bottom-up approaches, top-down approaches – and really think about what suits best in each individual case.

**Dr. Siegel:** I'd just like to say they're all excellent points, but the point about the brain changes as adaptive changes in the moment helps people not blame themselves so much for it.

Think of it in that context – it's like, *Of course your brain did this. It was taking care of itself.*

## What Needs to Be In Place *Before* We Can Gently Start Nudging Clients Toward Change

**Mr. O'Hanlon:** The first thing I'll say is that Joan and I have always been interested in *multiple* approaches. We're eclectic; we don't have so much of an ax to grind like, "It's this way and only this one way of approaching change or trauma" – or whatever it may be.

And in this series, everybody's being exposed to a lot of different points of view and experts. But Joan and I have had to go *so deeply* into learning from other people.

That is a *really* good thing because we human beings, we tend to take a channel and get stuck in that channel – just like people do after trauma. They get stuck in a place – a particular set of beliefs, and habits, and body postures.

Being in this series, for me is just *broadening.* It gets you to question your assumptions – ones you didn't even know you had – and it gets you to learn that there are a thousand different ways, or 500 different ways, or 200 ways, or 10 ways to approach any particular person who's been traumatized.

And I *love* that because sometimes we do get stuck. We, as *practitioners*, get stuck.

And knowing that, "Oh, well there's the body, and there's yoga, and there's this, and there's eye movements, and there's hypnosis, and there's stories and there's this and that" – *so many* different approaches – it just makes me hopeful that there *is* a solution for people who come in traumatized.

I don't think we had so many tools 50 years ago. We have a *lot* now; we know a lot more about physiology, neurology, the brain, trauma. There's a lot more research, and there's a *bunch* of different approaches.

But the biggest single takeaway for me is when people have been traumatized and they suffer from the aftereffect. It's like they're frozen in time and they're frightened in a certain way that freezes them up.

We've talked about muscle freezing, but there is *belief* freezing, there is *relationship* freezing; there is also *perceptual* freezing – *physiological*, *neurological* freezing.

> "You've got to approach the patient as if they are a deer in the woods."

What I heard from almost all those practitioners is: you've got to approach the patient as if they are a deer in the woods that you've come across and they're frozen in that moment. If you startle them or approach them in an aggressive way, it's not going to work (for most people).

You have to approach them very gently, very kindly, and make sure they know they're safe. *Then* you can make a change. *Then*, you can help them make a change.

> "You have to approach them very gently, very kindly, and make sure they know they're safe."

It's that combination of that gentle safety and inviting them gently into change. *That's* the overall theme: that there are a *thousand* ways to make changes, but *that* is a key thing – making sure they feel safe. Because they *weren't* safe. You're inviting them gently into change.

## Where We Really See the Effects of Trauma Playing Out

**Dr. Borysenko:** Well, I second everything that Bill just said, and I want to thank you, Ruth, because, on a personal level, I learned *so much.* This was an exquisite series. And we got to learn so much about memory, attachment, brain science.

Trauma really gets us stuck in this helpless position in a certain point in time, and really *becoming* a

procedural memory – like riding a bike – so that that's the way we respond. It's a little bit like our attachment history; we respond and relate to other people in the way that our parents originally responded to us.

"We respond and relate to other people in the way that our parents originally responded to us."

I began to recognize that trauma has such widespread effects on our life, and especially in terms of our relationships – I think it was Allan Schore who said something like, "Left-brain insight is not the key. *Relationship* is the key."

*That's* where we see the effects of trauma really playing out.

One other really big take-away for me was Bessel van der Kolk. He mentioned, "Well, how do you know when the therapy is successful? How do you know when the person has had enough treatment for the trauma?"

"The person has had enough treatment for the trauma when they can manage to ***be with themselves*** in real time."

It's essentially when they can manage to *be with themselves* in real time; that they can go inside and now have the resources to be present to and manage what's in there.

Most all the techniques, at some point or another, seem to converge in mindfulness and that ability to witness, to notice, to stay present to what's happening, to recognize, *Ultimately, it's safe, because I will not be stuck with these negative emotions forever. If I just can be <u>with</u> them for a bit, they will change.*

That's a kind of commonality that underlies many of the treatments.

But my main takeaway is this: there's hope for trauma.

"There's hope for trauma."

At times I've really wondered. Now I think, if a therapist is trained in a variety of techniques – somatic techniques, hypnotic techniques, traditional-wisdom techniques – they'll be able to work with clients in a way that was not possible in previous years. And I think that's really exciting. It means hope.

"If a therapist is trained in a variety of techniques, they'll be able to work with clients in a way that wasn't possible in previous years."

## How to Tell When You Need to Adjust Pacing with a Client (and How To Do It)

**Dr. Buczynski:** I'd like to get into pacing because I think that's so important, and the series really reminded us of how important pacing is in treating trauma.

Can you give an example of a time or how you knew that you needed to adjust your pacing with someone, and how you changed the pace with a client?

**Dr. Siegel:** I think this is *the* crucial take-home point. It's all rich and interesting, but this one I don't want to forget myself, and I don't want our listeners or viewers to forget either. This is the area where we have the most potential to do harm.

In our therapeutic zeal, if we lead people out of their window of tolerance – and don't *get it* that we've led somebody out of their window of tolerance (which, it's okay to blow it, because we're always going to be making adjustments) – and we don't listen to the feedback that we're out of a window of tolerance, that's where things get particularly problematic.

> "I find myself adjusting pacing every ***minute*** in therapy."

I find myself adjusting pacing really every *minute* in therapy, as I've been thinking about it, and this series has helped me to think about it more.

Whether I'm explicitly treating trauma or not – *How uncomfortable does the client seem at this moment, as we're talking about whatever, or exploring whatever it is we're exploring? How trusting is the other person about the relationship at the moment? How much do they have faith that I intend to do no harm and I'm going to be there for them? What resources do they have <u>today</u>?*

> "People's sense of being resourced or not is based on attachment history, biology, and trauma history—but it varies day by day."

People's sense of being resourced or not is based on attachment history and biology and trauma history and all of that – but it varies day by day.

How much sleep has there been? How much of a viral load does a person have if they've gotten up a respiratory infection? All of these things affect senses/resources.

How stressful is this period in someone's life? – We don't want to start doing the big uncovering work at a moment when somebody's worried they're going to lose their job.

It's a very iterative process, where we're constantly making adjustments: *Is it a little bit too fast or a little bit too slow?*

In terms of the examples, sometimes the error is quite obvious.

I think of a woman with a very bad trauma history, and I've worked with a long time. She was telling a story about a date, and a guy was being weird with her – as guys often are – sitting a little too close, being a little too forward.

Because of her history, this became quite overwhelming to her.

And as she's telling the story – a story which, if somebody didn't have a bad trauma history, would be another unfortunate example of guys being insensitive – I saw her starting to get glassy-eyed, and the cadence of her voice started to slow down, and it was as though she were talking underwater or something like that.

I said, "Okay, we're entering into a hypoaroused state."

And, indeed, she started saying, "I feel spacey now."

And that was a cue – an obvious cue. "Let's not keep going down that path. Let's look out the window. Let's come back to the body. Let's come back into the safe confines of the room."

But other times it's *much less* clear.

I think about a fellow I was working with for a long time who struggles with depression but is quite capable and competent in the world.

I thought we were on pretty familiar ground; we were talking about marital dissatisfactions –he's had a troubled marriage where he constantly tries to please his wife (in his understanding of it of course), and she's constantly dissatisfied and is very often angry with him.

He's not someone who's overtly angry very often. And we were talking about that and, as we often do, strategizing about how he might respond.

What I *didn't* learn about until the next *week* was, for whatever reason, this brought home to him the imbalance in his marital relationship in a way that our previous discussions hadn't, and he sunk into a *very* desperate depression, being filled with self-criticism, feeling that he was lacking the courage to speak his

truth out of fear of her anger, and – he's a very ethical guy – feeling morally deficient because of this.

I thought we were just having another conversation about this chronic problem. So sometimes we might miss it *entirely* and not even hear about it till the next session.

So, my take-home point from the various ways we can *miss* this is it's a good idea to check – "How do you feel, talking about this?" – it's a really useful question to ask, even when we think it's going just fine. We can take that feedback and collaboratively make adjustments.

> "It's easy to trust our judgment and ***not*** ask the question—but it's ***wiser*** to ask the question."

It's easy to trust our judgment and *not* ask the question – but I think it's *wiser* to ask the question, even if it seems like, "Why are you asking? Everything's fine."

## Helping Clients Titrate Positive and Negative Emotions After Trauma

> "Pacing is absolutely key to trauma treatment."

**Dr. Lanius:** I agree, Ron, that pacing is absolutely key to trauma treatment and we have to think about it every *second* of our treatment.

Starting with the broad picture, we may not think that *getting better* is something frightening for people – but what I've learned, through my own mistakes as well, is that getting better can be *terrifying* for people, because they're used to a certain way of life.

They may be used to not having a sense of self, and now, all of a sudden, you start developing a sense of self; your relationships start to change as you get stronger; your wishes for what you want to do and what you don't want to do change.

> "Getting better can be terrifying for people, because they're used to a certain way of life."

Getting better is *incredibly* frightening for a lot of patients, and it's really key that we discuss that in treatment and that we pace it and that we titrate it.

I always talk to my clients that "Trauma therapy is all about titration – of everything: of positive emotions, of negative emotions, of your fears of getting better."

To put that out in the open – "What's it like for you to think about getting better? Is that frightening for you? Is that not frightening? Is that positive? Is that negative?" – and *not* **make the assumption that getting better**

> "Don't make the assumption that getting better is a great thing that everybody is going to feel comfortable with."

is a great thing that everybody is going to feel comfortable with.

As Ron said, we have to titrate positive and negative emotions, and our clients often are overwhelmed by positive emotions, and they also are incredibly overwhelmed by negative emotions. They also have tremendous difficulty experiencing positive emotions – just like Ron talked about earlier, with having to titrate self-compassion.

> "We have to titrate positive and negative emotions."

Really keep in mind that by fostering somebody to experience positive emotion, that may really be traumatic for them and push them into severe negative emotional states – and so to be really mindful of that.

Yes, we have to titrate negative emotions down, and we have to titrate up positive emotions – but again it has to be paced right, and it has to be done collaboratively with the client.

I have a case example of where I tried to titrate up positive emotions with an adolescent I was working with.

She had severe attachment disruptions – had never experienced affection from anyone in her life, and a severe history of physical and sexual abuse (again, throughout most of her life).

She was an in-patient, and I saw her daily on an in-patient unit. And I tried to really teach her how to begin to tolerate positive emotions.

I did the whole psychoeducation piece about, "You know, it's very difficult for traumatized clients to tolerate positive emotions and so we really have to titrate it. We will get you to only experience a second or a millisecond of positive emotion, so we'll do it very carefully. I want you to think about some positive memories you've had."

It was almost *impossible* for her to come up with any positive memories for *days.*

Towards the end of week two, all of a sudden she said, "You know, Ruth, I have a positive memory now, and it's my relationship with one of the nurses." She felt more comfortable with this nurse.

And I was already a bit concerned because it was a nurse; it was nothing from her childhood; it was so late; it was about a relationship in the hospital – but I thought, *Okay, we'll go with it. I'll just get her to bring up the image of her with the nurse for a millisecond, because, again, we're going to try to test how much positive emotion she can tolerate.*

And literally she brought up this image for a millisecond.

> "Both negative and positive emotion can be incredibly powerful and we have to pace and titrate to exercise caution."

When the image changed, the nurse abandoned her, left her, and she went into self-abusive behavior; she started hitting herself to the point where I had to restrain her. I've never restrained a patient since then; I think it was the only time in my career where I needed to help and restrain the person.

That taught me very early on, both negative and positive emotion can be incredibly powerful and we have to pace and titrate and really do it in a collaborative way but, again, to exercise caution – because that's certainly not something we want.

**Dr. Siegel:** It's such a good point and I'm struck by how our own wishes and needs – which might be, *Oh, I want the person to be better so I can feel like I'm successful as a therapist* – could be very counterproductive here.

> "Our own wishes and needs could be very counterproductive."

## When Questions About Trauma (and Its Treatment) Create More Questions

**Dr. Buczynski:** Joan, I suspect that a lot of people had a *lot* of their questions answered by watching the series, but sometimes there are times when you hear something and it does answer *some* questions but that can also leave *new* questions. You know, where you'd sort of get a sense of something but then you become curious about something new in that regard.

Did that happen to you in this series? And if so, what are some of the new questions that have come up for you as a result of this series?

**Dr. Borysenko:** Well, I had a *number* of questions come up. One of them is, in the news these last couple of months, there's been *so much* about women who've been sexually abused in some way. It's coming up with various movie stars, political figures – everywhere you go.

I have a friend who was actually raped. In the court system, her case was dismissed and she was *really* traumatized by that because she was not believed. Apparently the court system is not very kind to women who are bringing a case against rapists or trying to defend their own behavior. There's a tremendous amount

of stress there. And addressing that seems to be a very important question.

And part of this, like what do you do if you were raped on a date? Or if you're given date-rape drug and wake up later and realize you're been violated?

I began to think about some of the things that Bill was talking about – for example, the use of propranolol, a very simple, inexpensive beta blocker, to block the consolidation of short-term memories into long-term memories. That would seem a really good thing to do.

And then, as I thought about that – and this is *so* unlike me, to think about pharmacologic approaches but I like to really cover the full spectrum – I was thinking about all the people traumatized through the opioid crisis, who had a loved one die in front of their eyes.

There's a whole cadre of people who've been traumatized by that.

What do we do for *those* people so *they* don't end up dulling their pain by taking more opioids and having an unfortunate end themselves?

That brought back to me the memory of a book – I think once I talked about it on this series, Ruth – it was called *Shivitti: A Vision.* It was about an Israeli who had been tortured during the holocaust; it was a torture survivor.

There was a guy by the name of Jan Bastiaans, a psychiatrist in Holland who did LSD psychotherapy, and he *completely* – you know, talk about images and perceptions – he *completely* changed people's perceptions of the trauma.

Then I thought about some of the new research with people who are really traumatized by the thought of death, and they are approaching death and they are not at peace. The use of MDMA with those people could help to become peaceful, and then the use of neurofeedback.

These are all things that change perceptions, that change the brain.

I started to think, *My goodness, there are a lot of approaches to trauma out there that are as yet to be discovered or researched.*

***"There are a lot of approaches to trauma out there that are as yet to be discovered or researched."***

**Dr. Siegel:** It just so happens that a new question came up for me yesterday.

In general, thinking about the trauma series has certainly sensitized me to how many of my clients are struggling with trauma, including those where maybe it's less obvious because it's less big, key trauma.

> "The Trauma Series has sensitized me to how many of my clients are struggling with trauma."

One set of questions that came up – and it just came up yesterday – has to do with public events that are traumatizing to our clients or patients.

Now, some of these are very idiosyncratic – like there's a news story about a bad traffic accident. I have a patient whose son was in a bad traffic accident and suffered some brain damage – he's mostly okay and it's years later – but when stories like that come, that's retraumatizing to her.

That's not a surprise – and we'll work with that – as it makes sense that she'd be particularly sensitive to that.

Others are somewhat more universal – like when there's a terrorist attack somewhere in the world and it just adds to our sense of insecurity. Particularly if there's a terrorist attack close to home or where our loved ones live or things like that.

There too, we can universalize it a bit but understand the particulars of how it affects a given individual.

But it occurs to me that some of the things that are traumatizing to a lot of my current clients have to do with *cultural events.*

> "Some of the things that are traumatizing to a lot of my current clients have to do with ***cultural events.***"

These are very tricky to deal with, because we try to have therapeutic neutrality in order to maintain the therapeutic alliance. We don't want to come out with some particular political stance or some particular position on the culture wars, because we don't want to alienate somebody who may have a different point of view. That's certainly very important.

But I've had a lot of people triggered by what we might call public examples of a resurgence of awareness of sort of "toxic masculinity," or "patriarchalness" – that kind of thing.

Some came from some of the incidents that happened around what was then candidate Trump, around attitudes towards women.

There was the media mogul Harvey Weinstein where suddenly it came out that he had really abused and assaulted so many women.

In general, these stories of famous people being abusive are quite triggering.

There was this campaign that went viral instantly on Facebook and Twitter called "Me too." It was following the Weinstein incidents, and all sorts of people are reporting on their "me too" sexual assault experiences.

There was a recent ABC News/*Washington Post* poll that showed 54% of women reported some kind of unwanted events this way, and there were some 30% where it happened in the workplace, and often it was from men who were in positions of authority, where they felt they had too much to lose by saying anything.

It raises the question – when should we take a more political or social-activist stance around this?
It *can* be helpful to people in resolving trauma, to kind of band together with other people who have experienced a similar kind of trauma, and do something to try to enact some kind of social justice.

A friend of mine, Terry Real, has written a lot about problematic masculinity. He says – and I found it a fascinating question: "If dentists knew that eating a lot of sweets or not brushing your teeth were a problem, they wouldn't say, 'But it's a free choice!' They'd advocate for doing something about eating sweets and not brushing your teeth."

We're in a much more complicated position because these things are so loaded, particularly in terms of the culture wars and in terms of the political divisions that are happening in the US and the world – more broadly.

> "When ***should*** mental health professionals take a more proactive stance?"

It left me with a question: as mental health professionals, when *should* we take a more proactive stance, and talk about these things as broad cultural problems – "Perhaps you might feel empowered by in some way banding together with other people, to try to publicize or do something about this?"

When is that our *own* political agenda, our *own* position in culture wars, just getting expressed? I think there's dangers both ways. There are dangers to *not* addressing this stuff because we're trying to be really neutral. And there are dangers to *addressing* it, because we could alienate our clients, or we could just be involved in our own agenda.

That was a big question, and it was really inspired by the fact that so *many* of the people I'm seeing in treatment are being traumatized by these kinds of public events.

## How to Work with a Patient Whose Sense of Time Has Been Damaged by Trauma

**Dr. Buczynski:** Bill, we talked a lot about how trauma impacts a person's sense of time. Can you help us make sure that we know how to identify when this is actually happening in the moment?

And can you also share a story of a time when *you* realized that somebody *you* were working with had had their sense of time damaged because of trauma that they'd gone through? And how you helped them regain a healthy sense of time?

> "When people are in the aftereffects of trauma, it's like they're in a bad trance and the trauma memory is almost like a black hole."

**Mr. O'Hanlon:** When people are in the aftereffects of trauma, they're like in a bad trance – again, you know, my background is in hypnosis somewhat. It's like they're in a bad trance, and the trauma memory is almost like a black hole, kind of sucking them in: the gravity of going back to the past.

And this wasn't a client but a colleague – I was working in a mental health center and this psychiatrist said, "Hey, you're going back past Doris's office to your office – right?"

And I said, "Yes."

"Will you tell Doris the meeting tomorrow is canceled?"

"Sure. Fine." I figure it's a simple little message I'm going to deliver. It turns out not to be.

I knock on her door – her door is open – and I say, "Doris, Dr. Sheer said that the meeting tomorrow is canceled."

And she started *yelling* at me. And usually when people yell at me I'm all freaked out – but it was so *clear* I hadn't done anything.

I let her vent and I said, "Doris, I don't know who you're mad at but it's clearly not *me.*"

I could *see* her reorient in time; it's like she shook herself, came out of that trance.

She said, "Oh, I'm so sorry, Bill. They promised me a raise and a promotion." She was a part-time administrator and she was going to become a full-time administrator. "It's just like my father and just like my ex-husband; they promise and they never fulfill their promise."

And I thought, *Well, I know whose face was projected on <u>my</u> face – from the past!*

> "They're bringing the past into the present, because the past has such gravity for them. Some aspect of them is stuck in that moment."

That is a quick story to tell you how I generally work with clients like that – you want to wake them up.

We've talked about mindfulness and being present. They are in the past. They're frozen in time in the past, and they're bringing the past into the present, because the past has such gravity for them. They're stuck in that moment. Some aspect of them is stuck in that moment, and they may bring it to the present again and again.

Part of the way is just to notice, *Oh – I'm not <u>here</u> anymore. I'm there*.

Just to be aware when the bad trance happens, and *wake up in the moment*.

I think of a couple of examples of clients – one would just slip right back into the old trauma as if it were happening. She just reached out her finger and said, "Grab hold of my finger so I remember I'm here in the present."

So, it's sometimes just to touch something physical in the office, just to keep you grounded in the moment.

We remember Gestalt when they bring you right back to the moment, sensory awareness in the moment, to wake up from whatever it was you were caught up in.

*That's* the way to come out of that old sense of time/history repeating itself, is to be present. We've talked about many, many ways to do that. There are sensory ways, awareness ways, and mindfulness ways to come out of a bad trance. It's really a way to wake up from a bad trance.

> "The way to come out of that old sense of time is to be present."

You can use trance for healing, but this is a trance that keeps repeating the past again and again and recreating it. So I think *waking up*.

> "You can use trance for healing, but this is a trance that keeps repeating the past again and again."

## One Practical Way to Influence Gene Expression

**Dr. Buczynski:** Joan, in the series we talked about epigenetics and the idea that genes can turn on or off based on experiences that you have or based on things that are happening in the environment. How does this influence how you work with someone who's experienced trauma?

**Dr. Borysenko:** Well, here is a very interesting thing.

I always have to bring up nutrition, but there's something very interesting here.

For example, studies of kids who have been bullied – what goes on is they develop an epigenetic change that makes it more difficult for them to do something called *methylation*.

That means adding a methyl molecule to the histone proteins (that's kind of like the spool that the DNA is wrapped around).

If you don't have enough methyl groups to silence your genes, you'll have genes activated when they should not be activated.

"If you don't have enough methyl groups to silence your genes, you'll have genes activated when they should not be activated."

One of the things that controls methylation is actually diet, which can help offset the effects of stress.

I've often thought of this in regards even to our troops, who are eating K-rations; this is *not* helping the body to methylate, and what goes on in terms of the trauma of war or the trauma of bullying affects the methylation.

What *really* helps is eating a lot of greens – and the word *folate* (folate is important to the methylation system) and *foliage* come from the same root.

But the idea with epigenetics is it's not just *one* thing that affects gene expression. The largest effect is actually what we *eat.*

Of course, our beliefs affect it. You had a blog very recently about Rachel Yehuda's work, which looked at how trauma can be inherited for several generations – and I was really very interested.

I just want to complete my thinking here in this way – so frequently, we come across a patient, or maybe it's we ourselves, and we begin to think, *My goodness, there's a lot of trauma history here.*

That person had an epigenetic history of slavery, or an epigenetic history of coming from a country where

> "We don't necessarily need to know the story; we need to deal with the effects."

there was oppression of a certain class of people, or they had a holocaust history.

There's that – but so many *other* kinds of traumas exist that sometimes I think, *My goodness – let's choose between the traumas. Which one is it?*

It shows again that we don't necessarily need to know the story; we need to deal with the effects.

> "If we would all just eat more plants and greens, a lot of trauma that's out there wouldn't take root to begin with."

We live in a highly traumatic culture, and – I'm going to sound like your grandmother – if we would all just eat more plants and eat more greens, we would have longer telomeres, much more resilience, methylate well – and I think a lot of trauma that's out there would not take root to begin with. So, there's your nutritional byte for the day.

## The Future of Trauma Therapy: The Questions We'll Be Asking in Five Years

**Dr. Buczynski:** Bill, if you had to predict, what are some of the questions that you'll be asking in five years?

**Mr. O'Hanlon:** There's three main areas that I think about the future questions, or present-to-future questions – that are interesting.

One is – we know a little about this – but why are some people so much more resilient and not as prone to post-traumatic troubles as others? And how can we use that to prevent post-traumatic stress?

That leads to the second area, which is prevention. One is studying people who are more successful at dealing with trauma, and that gives you some ideas.

The second one is *how can we do prevention?*

There's some interesting research going on in Canada and other places. Right after trauma, you give somebody a medication that blocks making short-term memories long-term memories.

And you think, *Wow!* We now know the pathways of creating traumatic stress and traumatic memories – and

> "We now know the pathways of creating traumatic stress and traumatic memories."

they just give this simple medication and people sometimes don't develop that post-traumatic stress stuff.

One of the people you've had as an expert, Kelly McGonigal – her sister is a gamer; I don't know if you know much about her, but she's done TED Talks, and she's an amazing person.

She got a head trauma and she used videogames to heal. She created a videogame – a real-life videogame with her friends – and she got points for this and points for that, and she found allies, just like you do in a videogame.

*That* seems to me a really exciting thing because we're so grim sometimes in psychotherapy, in doing the stuff we do, and we do see grim things – but that seems a lighter way of healing.

And I think *that* kind of stuff could get to younger people who are on their screens all day.

That's where they spend their time. They may not go to therapy – but they might use an app, they might use a videogame to heal. So that's pretty cool.

Sort of opposite that, the question we're going to ask is *how can we help people connect?*

Just like we see rising rates of depression in recent decades – *why?* Has people's neurology changed? Maybe. Have their biomes changed? Maybe. But I think we're disconnected. And I think one of the things that happens in the wake of trauma is disconnection.

So how can we help people in this age of everyone staring at their screens and being disconnected and being so busy? How can we help people connect?

Some of the research suggests that prevents trauma or helps people heal from trauma. When they feel isolated or alone, they don't heal so well.

So I think those are the questions we're going to be asking: *What can prevent and heal trauma more quickly? And why are some people more prone or less prone to trauma?*

**Dr. Buczynski:** Bill, what is Kelly McGonigal's sister's name?

**Mr. O'Hanlon:** Jane McGonigal. If you look it up on TED Talks, she created a game to heal from brain trauma and it's an *amazing* thing. It's been used for people with depression, with emotional trauma, psychological

trauma, physical trauma, and brain trauma – and it's amazing.

It's *SuperBetter*.

That's a terrific game. It's free online. Anybody can use it to heal from whatever they need to heal from. It's a cool game.

## When Shame, Guilt, and Self-Loathing Are at the Core of Trauma

**Dr. Lanius:** I hope that we will be talking more and more about this – not just here but also within the trauma field.

> "Patients with PTSD and trauma-related disorders experience an incredible amount of shame and guilt."

Patients with PTSD and trauma-related disorders experience an incredible amount of shame and guilt. To date, we focused a lot on fear and a bit of anger – but shame and guilt, even though it is in the literature, has not been a focus.

When I talk to a lot of my veterans or my first responders – and of course also the childhood-abuse clients – shame and guilt is really at the core of what they experience, and they feel permeated by their shame; their shame prevents them from making eye contact, from having social interactions, and really from having a normal life.

> "Shame and guilt is really at the core of what they experience. Their shame prevents them from having a normal life."

And so *how can we think about shame and guilt more and its treatment, to really make it a focus?* I think that will be an important topic in the next several years.

A related concept to that is also what is very common in traumatized clients, and we always see it – that concept of self-loathing. People often feel incredibly bad about themselves; they feel non-deserving – and that relates to the incapacity to experience positive emotions; and it is very related to shame.

> "People often feel non-deserving. That relates to the incapacity to experience positive emotions. It's very related to shame."

So, how do we work with self-loathing? And how is that related to really have internalized, often, the person who hurt you, again in

an adaptive manner?

When you do that at the time of the trauma, when you sort of internalize the person who hurt you, that gives you a sense of control and a sense of hope.

If you feel, *I'm bad. I deserve to die,* that means what gives you a sense of control and hope is, I*f only you change something, if only you become different, this situation will end* – as opposed to thinking, *There's nothing I can do about it. It's all in the hands of the perpetrator. There's absolutely nothing I can do.* I think that would lead the person to shut down and die.

> "Something we need to think about more and more in therapy is to directly deal with this internalization of the person who hurt us."

So, something we need to think about more and more in therapy – and I've certainly learned this through my own mistakes – is to directly deal with this internalization of the person who hurt us, and help the client understand *why* and *how* to bring this part of the client into the present, to really help them have a sense of control and a sense of hope in the present that doesn't behave like it was the past.

So, to help them use that part of themselves in the present, to move forwards – almost to change the sense of time of that part of them.

> "When we're sitting in the therapist's chair, we're typically not blaming our already abused client or patient. So we're more likely to miss the way that they may feel that it's somehow their fault."

**Dr. Siegel:** I think that's such an important point and so easily missed, because when we're sitting in the therapist's chair, we're typically not blaming our already abused client or patient; we're thinking, *Oh, poor dear who's gone through this.* So, we're more likely to miss the way that they may feel that it's somehow their fault.

**Dr. Lanius:** I've certainly learned through my own experience the sooner we address this issue directly, head-on – and it can be difficult, but – the quicker the therapy progresses, and the less we stall in therapy.

## The Importance of Working with the Subconscious Triggers That Can Impact Clients After Trauma

**Dr. Lanius:** The last thing on my wish list is that we're learning now that our trauma patients are affected by

> "We're learning now that our trauma patients are affected by a lot of triggers they're not even ***conscious*** of."

a lot of triggers they're not even *conscious* of.

So, when you expose somebody to a stimulus or trigger, even for 14 milliseconds that can't be consciously interpreted by the brain, they're incredibly affected by this trigger – actually more so in terms of heart rate variability changes than conscious triggers.

So how can we really work with subconscious triggers that our patients are so affected by? How can we incorporate that into our therapeutic thinking that, yes, there's a lot of *conscious* triggers but there's also a ton of *subconscious* triggers.

How can we help people to become more aware of those *subconscious* triggers – you know, using different body therapies and, again, different integrative approaches?

> "There are a lot of ***conscious*** triggers but there's also a ton of ***subconscious*** triggers."

Which also brings me to the topic of what future adjunctive treatments do we need to think about?

We've talked a lot of treatments in this course, but something that I think is also up and coming is the use of neurofeedback, which is a form of biofeedback that helps us to retrain brainwaves directly.

Bessel van der Kolk has done some studies on this that have shown that this form of treatment can actually have a significant impact not just on emotional ability but also on cognitive function, which is so important in our traumatized clients.

Thinking more about how we can work directly *with* the midbrain – those lower parts of the brain that fire off these raw affective responses that are so difficult for our clients to dampen. The midbrain, as we talked about in this series, is also responsible for active and passive defensive responses.

> "How can we think more about treatment that directly targets that midbrain?"

So, how can we think more about treatment that directly targets that midbrain – such as Peter Levine and Pat Ogden's treatments?

There's also new treatments, such as the Comprehensive Resource Model, that are coming online that have good neurobiological theories and that really work to target that part of the brain directly through working with raw affective states in the context of secure attachment resources.

These are a lot of things that are going to be coming up more and more so in the next five years and that we

really need to think about, to help our clients to recover from the often devastating effects of trauma.

**Dr. Buczynski:** Thank you. Thank you very much for your perspective on where we need to go. It's *so* important for us; the field has grown so much in the last five years, and hopefully it will continue to have as much growth in the next five years as well. And thank you, Ruth; you are part of the people who lead the way in the study of that.

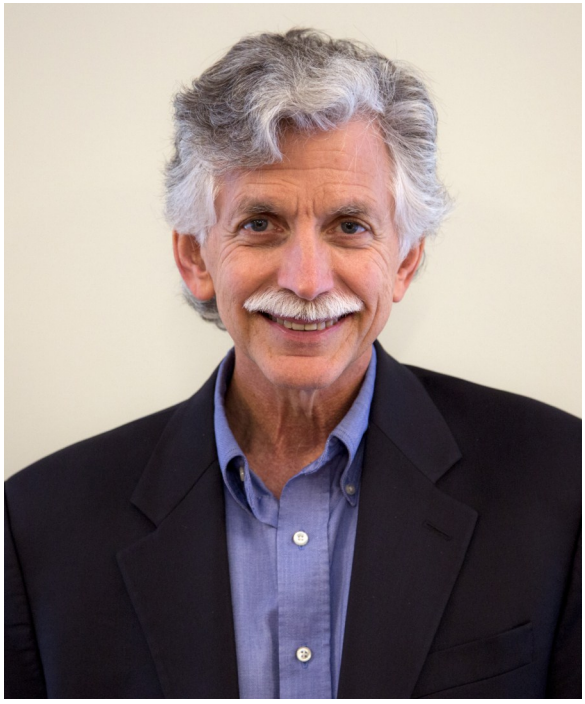
I appreciate you being here throughout this whole series because you bring such an important perspective, and it's so important to get this information out to everyone throughout the world.

# About the Speakers . . .

**Ruth Lanius, MD, PhD** is a professor of Psychiatry and the director of the PTSD Research Unit at the University of Western Ontario. She established the Traumatic Stress Service and the Traumatic Stress Service Workplace Program, both specializing in the treatment and research of PTSD and related comorbid disorders. She currently holds the Harris-Woodman Chair in Mind/Body Medicine at the Schulich School of Medicine and Dentistry at the University of Western Ontario.

She has authored more than 100 published papers and chapters in the field of traumatic stress, regularly lectures on the topic of PTSD nationally and internationally, and has published *Healing the Traumatized Self: Consciousness, Neuroscience, Treatment*, together with Paul Frewen.

**Ron Siegel, PsyD** is an Assistant Clinical Professor of Psychology at Harvard Medical School, where he has taught for over 20 years. He is a long time student of mindfulness mediation and serves on the Board of Directors and faculty for the Institute for Medication and Therapy.



Dr. Siegel teaches nationally about mindfulness and psychotherapy and mind/body treatment, while maintaining a private practice in Lincoln, MA.

He is co-editor of *Mindfulness and Psychotherapy* and co-author of *Back Sense: A Revolutionary Approach to Halting the Cycle of Chronic Back Pain.*

# About the Speakers . . .

**Joan Borysenko, PhD** has been described as a respected scientist, gifted therapist, and unabashed mystic. Trained at Harvard Medical School, she was an instructor in medicine until 1988.

Currently the President of Mind/Body Health Sciences, Inc., she is an internationally known speaker and consultant in women's health and spirituality, integrative medicine, and the mind/body connection. Joan has also a regular 2 to 3 page column she writes in *Prevention* every month. She is author of nine books, including *New York Times* bestsellers.

**Bill O'Hanlon, LMFT** is a psychotherapist, author, and speaker. He co-developed Solution-Oriented Therapy, a form of Solution focused brief therapy, and has authored or co-authored over 30 books, including *Out of the Blue: Six Non-Medication Ways to Relieve Depression.*

He is also a musician who plays guitar and writes songs.

# About NICABM . . .

**Ruth Buczynski, PhD** has been combining her commitment to mind/body medicine with a savvy business model since 1989. As the founder and president of the *National Institute for the Clinical Application of Behavioral Medicine*, she's been a leader in bringing innovative training and professional development programs to thousands of health and mental health care practitioners throughout the world.

Ruth has successfully sponsored distance-learning programs, teleseminars, and annual conferences for over 20 years. Now she's expanded into the 'cloud,' where she's developed intelligent and thoughtfully researched webinars that continue to grow exponentially.

**The National Institute for the Clinical Application of Behavioral Medicine** is a pioneer and leader in the field of mind-body-spirit medicine. As a provider of continuing education for health and mental health care professionals for over 20 years, NICABM is at the forefront of developing and delivering programs with "take home" ideas, immediately adaptable for practitioners to use with their patients.

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