Treating Trauma Master Series

How to Work with Traumatic Memory That Is Embedded in the Nervous System

a TalkBack Session with
Ruth Buczynski, PhD; Ruth Lanius, MD, PhD; and Ron Siegel, PsyD

National Institute for the Clinical Application of Behavioral Medicine

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Treating Trauma Master Series: TalkBack #3

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How to Work with Traumatic Memory That Is Embedded in the Nervous System

Dr. Buczynski: This is the part of the session where we're going to synthesize the ideas we just heard.

I am joined by two world-renowned experts: Dr. Ron Siegel (assistant professor of psychology part-time at Harvard Medical School), and Dr. Ruth Lanius (professor of psychiatry at Western University of Canada).

How to Help Clients Learn to Differentiate Between the Past and the Present

Dr. Buczynski: So let's start out and talk about what stood out to you both this week.

Dr. Lanius: I think the essence of this session is that the traumatic memory is not a memory that's remembered, but a memory that's *relived*. People will actually feel like the past is recurring. And this will happen at the level of mind, brain, and body.

> "Traumatic memory is not a memory that's remembered, but a memory that's ***relived***."

So people may act like they did at the time of the trauma; for example, if we're working with a veteran who hid when he heard the helicopter coming, that person may actually run and hide in the corner, feeling like he's back at the scene of the trauma.

The emotions that people felt at the time of the trauma will be relived like they occurred at the time of the trauma – so the anxiety, the terror, the fear or the shame. So people really don't have the capacity to differentiate what's past and what's present.

And when we think about that for a moment, I think that's *incredibly* incapacitating.

And I think, in extreme examples, people really lose the whole sense of time, so they have no idea how much time has just passed; they're between present and past, and they have no idea where they are. And I think it creates a huge sense of isolation in this world: you don't know where you fit in, you're completely lost, and you have no idea whether it's present or past.

Dr. Buczynski: Thank you. How about you, Ron – what stood out to you this week?

Dr. Siegel: Well, first I'd like to just point out that I don't think it's an accident that so many horror films have as their theme being lost in some way and being very uncertain about what's real and what's not – which is exactly what Ruth was just describing.

I was noting in this week's presentation that, it's unusual in the mental health field to get a group of people who all agree about something. But in this case everybody really did agree that the work needs to happen primarily in the here and now.

"Everybody really did agree that the work needs to happen primarily in the here and now."

And mostly, it's not going to be about talking about the trauma – not that there's not a role for that, but the critical thing is going to be *being with* feelings and body responses and the images associated with the trauma.

Bessel emphasized mindfulness, saying, "We need to increase our capacity to tolerate feelings and be with them as they arise." And Pat and Peter talked about needing to investigate body posture, action tendencies and the like to learn more about the trauma that way. It's all happening in the present moment.

And, as Bessel pointed out, if you're describing a coherent memory of the trauma, well then treatment's over – like that's kind of the end, because that only comes once we've been able to fully feel all of these different other components.

And I think it's very useful as a guide for all of us going into this to not think that we're supposed to *recover something.* This isn't a Freudian archeological dig *of Let's get back to an interpretation that describes accurately what once happened,* because for one thing, we never accurately know what once happened – you know, memory is not like a videotape; and for another thing, it's the psychic reality that matters anyway – it's the *experience* of what this *feels like* to us that matters.

And I thought that this session's interesting and varied perspectives on this were all very helpful as reminders clinically that we need to ask, *What's happening here and now in your experience?*

How to Help Clients Create a "Grounding Kit" to Soothe the Flashback Experience and Bring Them Into the Present Moment

Dr. Buczynski: Ruth, let's talk about flashbacks. What are some specific ways that you've worked with clients

who have had flashbacks, and how can we work with a client's nervous system to soothe or slow the flashback experience?

Dr. Lanius: I think the key is, when somebody is in a flashback, they're in the past; they don't know that they're in the present. And so, the critical part is to bring the *mindful* brain online—that prefrontal cortex that helps us to know where we are, have a sense of time and know what we're feeling in our body.

"The critical part is to bring the *mindful* brain online – that prefrontal cortex that helps us to know where we are."

Because when people are in a flashback, they've really lost that connection with those higher-brain functions that help us to put everything in perspective.

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And so I think the way to reestablish some of those connections is through sensory input –using the five senses: *Sitting on the chair what do you feel? Do you feel your butt sitting on the chair, touching the chair? Do you feel your arms on the chair? What do you see?*

And here again, I think the therapeutic relationship can really be helpful: *Look at me. You're safe here* – bringing people back to the present: *You're in the present. No one's going to hurt you here. Look at me. You don't have to make eye contact if you don't want to, if it's too triggering, but just notice that I'm here with you, you're in my office, you're safe, nobody's going to hurt you here.*

Some people have favorite smells – a perfume or some essential oils that they like to take out and really help to bring them back to the present through that sense of smell.

Different people have different ways of coming back into the present, and what we do with people is, we get them to create their own "grounding kit" and so whenever they're triggered and whenever they lose touch with the present, we help them to use the five senses to bring them back into the present.

Case Study: When a Flashback Is a Form of Self-Punishment

Dr. Lanius: I have some patients who have an *excessive* number of flashbacks – one flashback after another.

And what I've learned from talking to people is that when people have flashbacks at that frequency, it can also be a form of self-punishment and self-abuse, and often, when people have a lot of self-loathing, they will push themselves into experiencing a flashback.

> "When people have a lot of self-loathing, they will push themselves into experiencing a flashback."

For example, I had one man from Iraq; he was in the military there. He felt *terrible* about some of the deeds he had performed in Iraq, and he felt terrible that he'd left his family to come to Canada. He felt absolutely *disgusted* with himself. And he would be in session with me and go from one flashback into the next.

And I thought, *Wait a minute. Something's not right here. This is not usually how PTSD presents; you know, people sometimes have two or three flashbacks a day, and that's a lot, but to have these constant flashbacks one after another . . . Something's not right here.*

And so, I asked him, "You know, I wonder whether you're actually pushing yourself into these flashbacks because you feel so terrible about yourself and it's a way of punishing yourself."

And he said, "Yes, that's exactly what I'm doing."

So I think that's something also to be aware of – and if that's the case, I think that's something we really have to target in treatment.

Dr. Buczynski: Thank you.

Why Pacing Is So Important in the Treatment of Trauma (and How to Tell When You Might Need to Adjust It with a Client)

Dr. Buczynski: Ron, I talked with Peter Levine about the importance of pacing in treatment, especially when it comes to working with traumatic memory. Can you talk about how you've paced the treatment of a client who is healing from trauma?

Dr. Siegel: I think this idea of pacing or timing is critical, and the profession is kind of late coming to it as an area to explore and be attentive to.

As late as the 1970s, I remember people treating trauma with the idea of, *You've got to get back in there and feel the feelings; be with it and connect to your experience.*

And it really wasn't until Judy Herman's work in *Trauma and Recovery* and Bessel's work that people started saying, "No – you've got to go in stages. We have to establish safety first, and only once we've established safety, *then* do we venture into this work of reintegration or no longer dissociating" – basically relaxing defenses.

> "If something was traumatic, it was too intense to integrate – at least at that moment. We've got to have some reason to believe that they now have supports in place that they didn't have before."

And by definition, if something was traumatic, it was too intense to integrate – at least at that moment. So if we're going to invite somebody to move into that material, we've got to have some reason to believe that they now have supports in place that they didn't have before, and those supports are now going to be sufficient to hold them.

What stands out most are the cases where I didn't do this accurately. One clinical case that comes to mind is one person who had a really bad trauma history – and also her brother had committed suicide, and some current events had arisen that were bringing that back into her awareness.

We thought, *Okay, well, let's explore this*.

She started writing about it, and as she was journaling about it, she became *very, very* dissociated – couldn't sleep, all sorts of energies coursing through the body. It clearly wasn't helpful. Not that it wasn't a good enterprise at some point, but the pacing was wrong; there weren't sufficient supports to allow her to contain that.

So we shifted from that to *You know what? This is probably not the time to be writing about this. This is probably the time to be connecting safely to other people who are in your life now.*

And that's what she started to do instead.

A *very* important part of this is the psychoeducation; for instance, if people could have a map that discusses pacing and what it might look like if the pacing is too fast – for example, when dissociative symptoms come up as opposed to feeling and being with feeling, then it's time to move backward and look for more safety.

I work a lot with mindfulness practices, and mindfulness practices really do kind of divide up into those that are more likely to support safety, and those that are more likely to do the work of helping people reconnect with split-off contents.

Most of the ones that foster or facilitate safety are practices that would go right into what Ruth (Lanius) was describing as her "grounding toolkit" – things like walking meditation where you're paying attention to the feet on the floor; listening meditation where you're listening to ambient sounds; nature meditation where you're looking at trees and sky and the like.

There are also equanimity practices where you imagine yourself being a mountain going through seasonal changes with a sense of continuity and stability to your "mountainness," even though there is a lot of change going on around you.

"All of us, as clinicians, should check in with our client about how this is going and whether moving into this material feels useful or feels like too much."

And, there are also Marsha Linehan's distress-tolerance practices –things like holding an ice cube and just discovering, *I can be with this discomfort. It's okay. It's safe to do that.*

Now with things like lovingkindness and self-compassion practices, we talked about the danger of backdraft; how the feeling of love may open the door to even *more* pain, so those practices we have to go into judiciously.

But I think all of us, as clinicians, should check in with our client or patient about how this is going and whether moving into this material feels useful or feels like too much right now.

Dr. Buczynski: Thanks.

How to Help a Client Feel Safe Enough to Revisit a Traumatic Experience

Dr. Buczynski: Because a traumatic memory can often trigger a reactive response in the nervous system, we need to help clients feel safe enough to revisit it.

Can you talk about a specific method that you've used to help a client feel safe enough to explore a painful, frightening experience?

Dr. Lanius: I think this brings us back to the window of tolerance.

When we do trauma work, we try to be really at the edge of the window of tolerance. So usually one of the first things I do is I draw this window of tolerance for people and I tell them that "This is where we want the work to be – either at the high edge, or at the low edge."

"When we do trauma work, we try to be really at the edge of the window of tolerance."

But we don't want them to become too hyperaroused and dissociated or too hypoaroused and dissociated.

"We don't want them to become too *hyper*aroused and dissociated or too *hypo*aroused and dissociated."

And then we talk about, how can we help to resource people to really stay within that optimum window of tolerance?

Two of my favorite resources to get people into before we do any type of processing is *sacred place* (I don't use the word *safe* place because *safe* can be a trigger, especially if people have never felt safe). A *sacred place* is a place that is either real or imagined, that feels completely sacred, where there are no intrusions, where there's no threat, there's no hurt. I often try to use a place in nature – and get people to identify that.

So, what is a sacred place for them? What does it look like? You know, whether it's by a lake or the sun is shining. I get them then to feel what they feel in their body in the sacred place – so, "Imagine feeling the warm sunshine in your body."

In order to get them to feel more grounded I say, "Now, imagine standing barefoot in the sacred place. Imagine the connection between you and the ground. Imagine roots growing from your feet into the ground. And just breathe. Notice your breathing while you're in the sacred place, in and out."

So that's something we can then use as a form of regulation, if they become too triggered when going through the trauma.

I think another important resource is an attachment resource. We've talked previously how important attachment is in relationship to the window of tolerance; how important attachment is as a foundation for emotion regulation; and of course how a lot of our clients haven't had that secure attachment figure.

So really going back – Is there any person in their life who they've felt safe with? Or do they want to use an animal? Or do they want to use a higher being? – and then using that as an attachment resource.

Getting the person in their sacred place might look like this - imagining making eye contact with either a person they felt safe with in their life, or an animal, or a higher being – just imagining making eye contact, imagining that sense of connection, and just *being.*

And repeating that over and over again – so when you get into the trauma work, you can call on these different resources to either reduce the arousal or enhance the arousal if they're too numbed out. You're staying at or within the optimum window of tolerance and right at the edge, and you don't push people into too much hyper- or hypoarousal.

Dr. Buczynski: Thank you.

How about you, Ron – how would you approach it?

Dr. Siegel: Well, in addition to those excellent approaches, I was actually thinking about something I once heard Thich Nhat Hanh say – he was a Vietnamese Zen master and he worked with a lot of people both during the Vietnam War and afterwards.

He would tell stories about people fleeing Saigon on the refugee boats. And it was a very chaotic scene, and this was a very traumatized group: they had often seen combat; they were separated from their families; often they were separated from their possessions; and their future was very uncertain – there was piracy and they were not clear which countries might let them in.

And he said that, on those boats, you could sometimes see one person who, for whatever reason – perhaps they were a Buddhist monk and they had done a lot of mindfulness practice or perhaps they'd come to it (he didn't say this) through extraordinarily secure attachment – but they were relatively able to bear the feelings that were going on.

And he said that around that person you could almost see concentric circles of people who were a little bit more regulated, a little bit better able to tolerate what was happening. And conversely, if there was somebody flailing around in fear and anger, there was a lot of dysregulation around *them*.

So from that, I think of something that Bessel said in this week's session, which is – it is our *own* practice, our *own* work at being able to be with and tolerate the full range of feelings that arise in us that is probably a critical resource in psychotherapy for helping people to reregulate their nervous system.

If we can be with the fear, with the anger, with sadness, if we can empathically connect to it, and even

generate compassionate wishes for the other, people *feel it.* People sense this in another.

That becomes very regulating and it's another way of doing exactly what Ruth was talking about in terms of imagining the place or the being or the like that can provide this kind of holding.

I can think of so many clinical cases where somebody was really quite overwhelmed with some kind of emotion and – if, on a good day, I had perhaps been doing a little bit more mindfulness practice or had a few more safe connections in my own life and was open to my own feeling experience – I was able to be there with a kind of presence that was just much more effective than on my bad days where I'm anxious, I'm distracted, I'm worried about what this means for me and I'm not so effective.

So it's only one method, and we're not the center of the person's universe, but while we're in the room, I think it's a very powerful part of what can be helpful.

Dr. Buczynski: Thanks. That's it for us for this week.

Thank you for all that you do – you do very, very important work in the world. Take good care, everyone.

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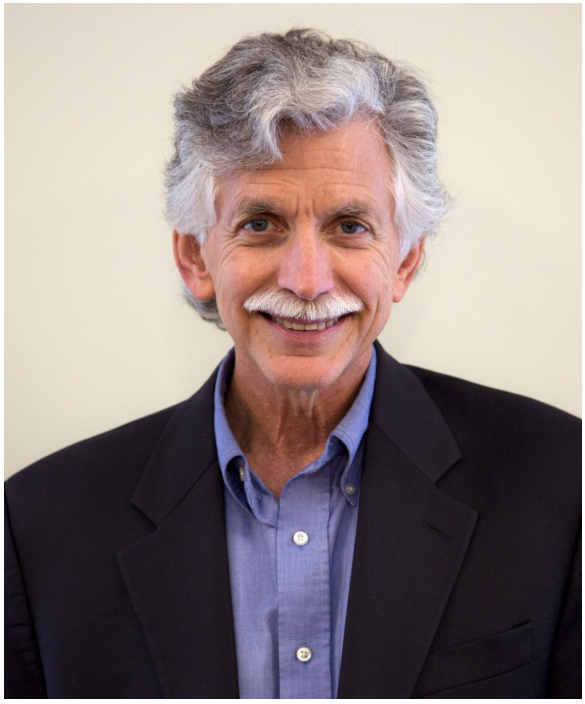
About the Speakers . . .

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.*