A scream away from happiness!?

When hope and risks are close together –

Bonding Psychotherapy with traumatized clients.

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Abstract of the lecture :

In practice, we are encountering increasing numbers of patients who suffer from the implications of traumatizing conditions, and traumatizing bonds in particular, from childhood. Individuals who have experienced physiological trauma are often thin-skinned and they become easily overwrought. They exhibit survival strategies and protections against decompensation, namely falling into dissociative states, avoiding emotional and/or physical contact, and separating themselves from their feelings. This mental state, which typifies traumatized patients, is not a positive precondition for body-centered treatments, such as Bonding Psychotherapy. Nonetheless, Bonding Psychotherapy tends to attract this clientele, who seek and long for healing. How can we modify our approach to treatment in order to work most effectively with these clients? We will be presenting and demonstrating several aspects our efforts to bridge the supportive effects of trauma therapy and Bonding psychotherapy in our clinical work.

Introduction [U:S:][1]

The best guide to working with clients, and in this case with traumatized persons, is to listen to their voices. As one example, I´d like to open by sharing “For Neil, Because You Asked” by Krishnabai, which I found in the book „The courage to Heal“:

For Neil Because you asked*...by Krishnabai*

Stress, long my enemy,
visits me often wearing long skirt,
which harbour her children
They creep out
when my back is turned
They try to overtake me.

The eldest, Fears is strong and cruel
He jumps on my back
arms around my throat
shrieks horrors in my ears,
and on fast feet I jump
out of the window
scream down the street
nto the dark horizon of night
and only much later do I return
ragged, weeping, alone.

Here`s how to care for me
when I´m with Fear:
move softly as approaching
a luna moth
have gentle, calm eyes
stay centered from my panic
and, if we ever
reach this place of safety -
just hold me

This poem mirrors the longing of many traumatized women and men for understanding, for the space needed to develop trust, and for holding and healing encounters.The message of this poem also reflects the motivation of our team at the Dan Casriel Institute to transform our view of traumatized clients.

Over the years, our team's therapeutic concept has undergone significant changes – more by evolution than revolution – which have been shaped by input from many sources: our own training in trauma therapy;

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1 *The authorship of each individuell part of the lecture is marked with the abbreviated names [U.S.] and [D.F.].*

input from colleagues from other fields and modalities of therapy;
our team's clinical experiences with bonding psychotherapy in general and using this therapeutic approach with traumatized clients in particular.
Our goal is to develop a therapeutic framework in which our traumatized clients can benefit from bonding psychotherapy while minimizing their risk of being flooded by traumatic material during the treatment.
We have observed that these adaptations also have beneficial effects for other clients, who are not traumatized.
I am grateful to Konrad Stauss for suggesting that we present this aspect of our work.
It is a particular pleasure to offer this material with my colleague Daniela Feuerhak. We work closely together and we have drawn essentially the same conclusions from our respective clinical experiences.
The narrative portion of our presentation will be followed by several demonstrations of our approach, including modified bonding exercises.

Discussion about changed therapeutic attitude[D.F.]
When I came across the bonding process as a client at the beginning of the nineties and later as a therapist, most of the clients came from the 12 step program, those in private psychotherapeutic institutes and those in hospitals. Abstinence of the addicted and attached to that the honest contact with own structures and the open confrontation with the partner was the paradigm. The therapeutic community, secondly space for the experience in the relationship as an important supporting pillar of the work and thirdly the emotional work. For many clients it was a good approach even for those with pre-traumatic experiences. Others became instable and we as therapists were left behind with the bitter knowledge that despite all efforts damaged rather than benefited these people and we couldn't anticipate and follow the trends which led to a negative prognoses. Esteemed colleagues mentioned as a consequence complex traumata as contraindication for bonding psychotherapy.
For us that would have meant dismissing clients, to whom we partially over the years built up a relation from the basic therapeutic process. We (the colleagues of the Dan Casriel Institute) wouldn't go that far, because we knew that their sensitive side would have been severely hurt. We still experienced

many positive developments beside all crisis.
It wasn't our aim to find the right clients for our therapeutic approach, but to mould the method to the special needs of our clients. Therefore we searched for new arrangements and found new ways. The new awareness's about attachment- resilience- and trauma-analysis offered us new perspectives. This reclaimed knowledge allows us to follow inner-psychological patterns better. These lend a special relevance to a bonding orientated approach. I do talk about the larger amount of our clients, the ones whom have a bonding trauma. We are increasingly dealing with people (and maybe always did, but never named it) whom experienced much pain by their main attachment figure in their earliest childhood, where normally they should experience shelter. If it was permanent physical, sexual or emotional violence, if it was the permanent negligence of their physical, emotional or mental needs. Bonding and defense systems are in this case activated at the same time, because biologically children are forced to approach. The "save-harbor" is at the same time a "mined area". Traumatized children, youths and adults have learned as a result of this a destructive bonding-structure and coping with stress in a dysfunctional way and they cling to it. They have a constitutional small stress-tolerance, as well as explicit deficits in the ability to regulate emotion and self-reassurance. People who have a disorganized bonding are more vulnerable. If we encounter clients with experiences like this, we have to know and learn to estimate the dynamic of traumatizing bonding and the impact of long lasting chronic traumatizing.

Traumatization:defining the terms and understanding the process [U.S.]
We do not use the term "trauma" in reference to <u>generally</u> hurtful or stressful experiences. Rather, this term is reserved to describe a life-threatening experience that meets three criteria which the German traumatologist, Michaela Huber calls the "traumatic tongs":

- Flooding fear (feeling close to death)
- Being totally at the mercy of a person or a situation (the inability to escape)
- Powerlessness (being unable to fight)

Traumatology has taught us that these experiences <u>aren`t</u> integrated in the

"memory archive" as other experiences are. Traumatic experiences and their correlated affects remain isolated and split off.
Neuro-Biology has provided interesting explanations for this process, but they go beyond the scope of our discussion.
More important in the context of our topic is the question:

How does this affect persons afflicted by trauma and what does it mean for therapists who use bonding psychotherapy with them? [U.S.]

Physically traumatized people are thin-skinned and they become easily overwrought with all the facets known as PTSD. This fact represents complicating precondition for cathartic, body-oriented psychotherapies, such as bonding therapy. Fragments of previous life-threatening experiences are easily triggered. The stimuli range widely, including specific constellations of contact, words, voices, smells…
Traumatized individuals experience this re-activation of traumatic material as emotional flooding, flashbacks and/or physical sensations.
These events are not recalled as memories, but rather, as a return of the original traumatic event as if it were occurring in the present.
Often this flooding is relieved by a return to the dissociative response.
In this state, traumatized people cannot differentiate between past and present experience.
Offering cognitive correctives, such as "It is over" will not reach them. Rather than offering comfort, such statements can be heard as insults or even mockery in the face of their pain because these clients <u>are</u> still experiencing the past.
Despite the harmful effects of our clients' maladaptive survival patterns, as clinicians we should to use care and caution in the process of reducing and ultimately supporting the replacement of such adaptations.

To illustrate, I will explain four observable risk factors:

- **re-traumatization from interactive pressure**
  For trauma clients greater interactive pressure does **not** bring about a reduction of their defenses. Instead, this leads to a breakdown and relapse into earlier states of trauma.
  Examples of "interactive pressure" include: the invitation to physical

closeness, intense emotional expressions and confrontations.

- **diffuse boundaries**
  Enthusiasm in the group – for example, encouraging physical closeness or raised vocal and energy levels – can be experience as peer pressure. Adapted behavior can result in the form of new transgressions of boundaries and/or anti-phobic behaviors. I suppose that most of us know situations like this: Clients act according to the principle: 'Grit your teeth and press on!' But what happens: Part of the client screams while another dissociated part in the basement of the soul is in panic. Therefore: <u>not</u> "a scream away from happiness', at all.

- **fragile self-perception**
  Traumatized people feel that they don't actually exist. They are completely identified with trauma-induced beliefs and damaging introjections from the perpetrator ("I am nothing", "I do not count", "It serves me right", "I am a monster"). Since confrontations with contrasting beliefs and attitudes can cause massive inner conflict for traumatized persons, they often need more gradual exposure to these new concepts than other clients.

- **difficulty achieving mutual trust**
  In a setting where bonding partners are exchanged frequently, individuals, who have been experienced attachment trauma lack the conditions needed for developing mutual trust. Furthermore, this environment can encourage unexplained projections and splitting.

These risks have led to our adaptations:

- Inclusion of paradigm and methods from trauma therapy
- Changes of setting
- Focus on fostering resilience
- Modifications of approach exercises, holding positions and rules for confrontation

Inclusion of the paradigm and methods of trauma therapy [U:S:]

There are different modalities of trauma therapy.

Here we refer to the stabilizing aspects of the Psychodynamic Imaginative Tauma Therapy (PITT), which was developed by the Dr. Luise Reddemann (her name is certainly known by many of you, particularly by our German colleagues).

Establishing a clear therapeutic structure and a transparent, non-confrontational therapeutic connection is an important starting point. Key aspects of methodology involve clients learning techniques that enable them to distance themselves from flooding emotions.
Another is a resource-oriented “therapy on the inner stage” which is based on strengthening supportive and healing fantasies, so-called “imaginations.

Case study # 1 [U.S.]

Trauma therapy interventions in the matwork
using an imagination as a tool to resolving a freezing, changing the history and finding a safe place

A chronically depressive client repeatedly experienced feelings of emptiness and hopelessness which were rooted in her experience as a patient in psychiatric hospital when she was twelve years old. Her persistent dull despair and resigned depression came into focus more clearly. She felt dead and numb. She had virtually no contact with her partner.
I reminded her of a nurse from the psychiatric hospital. The client had described the nurse as being different from the rest of the hospital staff. He represented a gleam of hope, but he also lacked the power to change the inhuman medical practices that she experienced.
I invited the client to give the nurse greater power and to imagine him leading her twelve year old self from the psychiatric hospital to a safe place.
The client imagined herself as a patient becoming younger and younger. The safe place was a green lawn. Finally the child was laying on the lawn, as if in a cradle or a womb. She listened to the sounds of

nature and she imagined a good, wise woman who was guarding her. To deepen this internal vision, the client asked the partner to open the window, letting in the sounds of birds singing and the river flowing outside. The client was snuggled up in a blanket on the mat. The partner sat at a slight distance in front of the client, taking care of her with her eyes. (Eye bonding)

In the course of her therapeutic process in group therapy, the client was able to pass through her dull, depressive despair for the first time. She experienced the deep grief that she felt as a child without becoming stuck in that state. This time she was able to express that something in her died when her mother placed her in a psychiatric and left her alone there.

Psycho-education also plays an important role.

We try to integrate the confusing and threatening experiences of our clients within a framework of explanation and interpretation.

Working with the “inner child” or the “younger selves” is essential.

We foster communication among different ego-states.

This process always involves creating distance from the immediacy of the traumatic event and developing greater self-care.

Daniela will go into more detail about that.

Alternate bonding methods [D.F.]

Especially people with boarder-line experiences, both emotional and physical nature, feel slightly flattened by our classical doormat.

Not just people who have been sexually abused (although we recognised this on them first) often react with panic when a stranger abruptly lies on them.

This applies to both the person in the active roll as to the escort.

We offer right from the start alternatives to “stop” which not every person who is traumatized can say, such as are alternate holding positions or contact offers.

To these count the classical holding mat, that is helpful especially in the process of nourishment, because at the same time as being hold, you have the opportunity of keeping eye contact. One has to be sure like with any other mat that the holder fulfils his role well and with a high presence.

Another option is the “mat of distance”; that especially for people with a clinging bonding style. In this case the mat starts close by and the holder has experiences with his feelings and thoughts when he leaves.
Other mats again, for instance those of sceptical people or one with negative bonding or no bonding behaviour, beginning at a distance. One works here with, similar to the advancing exercises, thoughts, feelings and impulses when the need for approach is activated. In the end destination is the experience and not the body contact.
We work with holding positions that children in different age groups prefer; laying down in small areas with the head on a rumbling tummy or for the older ones sitting next to each other, or just keeping eye contact. More than ever we ask the clients for impulses and we have experienced many alternatives in this way .
We accompany the mat experience over a longer period of time, for the safety of our clients and to be able to understand the dynamics of the mat.
Not so dangerous holding experiences are often offered as a release.
We do intervene more often.
When we know that loudness is a catalyst for flashbacks we split the group into a loud one and a quiet one.
Never asking for an emotional expression; we also make on the other hand the experience that for our patients that are not traumatized the silence determines important bonding experience.
This naturally does not mean that everyone has to be silent with us. We just want all ego parts on board.

Case Study #2 Trauma therapy interventions on the mat [U.S.]

The intentional use of separation

A client who had been severely traumatized by sexual violence of a near relative and who was quite experienced in psychotherapy entered Bonding Psychotherapy. Over the long term, she found this therapeutic approach to be both nourishing and comforting.
During one particular session on the mat, she came into increasingly clear contact with her anger over the pain that she had suffered. She wanted to express her rage aloud, but her voice failed. Nothing came out. Her throat

was cramping. In previous sessions she had experienced a similar desire to verbalize her feelings, accompanied by an inability to produce sound. With my suggestions to guide her, she realized that there was tremendous energy in her throat. It was the trapped energy that she experienced as panicked little girl who wanted to cry out but had to remain silent, who was terrified of being punished if she raised her voice, then and even now. With therapeutic support, the client was able to recall an experience of safety. She remembered her beloved grandpa, who was no longer living, who could always provide security and shelter. She imagined bringing that inner little girl to her grandfather now. From that point onward, she was able to express her strong adult anger.

Resilience support in the bonding psychotherapy and changed setting [D.F.]

Early attachment experience essentially develops the psychological resistance of a human. Long-term-studies have shown that in certain circumstances even negative prognoses can lead to a positive ending. Important in this connection are the promotion resource orientated personality aspects and a positive strengthening of the surroundings. For our setting this basically means the following. We have to establish security from outside. That means an explicitly marked anamnesis, which means more preliminary telephone-calls, longer introductions (to the parents disappointment) Questionnaires that are more complex and more detailed analysis. This also means more flexibility with the requirements of our clients, what are their special needs for protection, retreat and physical integrity and to establish appropriate conditions. For example that we increase working in smaller groups, integrating the inner child work with quiet, relieving methods, individual arrangements about time out or arranging breaks from the group. We are as sensitive as possible, affectively open and (long term) reliable. We take care that the setting leaves room for regular meetings and if required previous to the workshop and afterwards, in either case during the workshop. This clearing means that today we are going to work with smaller groups (at the most with 16 people to two therapists). If we become disconnected we have to click back into this disconnected communication, so clients who have never learned anything like this can make an experience of continuary

relationship. Together we are going to reconstruct history. Make sense of events that have happened, and research the biographies for important people and for reliable experiences, self-competence and self-confidence. Together we are going to design coherent stories and fill them with positive emotional contents. With the help of trauma therapeutic interventions we are going to meaningfully correct old memories. More than in former times we explain why we are doing something, feeding the heads of our clients, to make them understand. We allow them to put their experiences into words to integrate them, we practice getting into contact with their feelings and we show them how to actuate them, without being flooded by them. The catharsis, the emotional expression is not focused on, but on the careful approach of their own feelings. Not until figuratively “everybody is on board”, this means security in all areas or if they are in a safe inner place the emotional expression can begin in contact to the other, even if this isn't bodily. If dissociative situations, flooding or abreaction initiates itself and the contact to the partner can not be kept, we carefully disconnect the emotional processes and reflect the events together with both clients. Because contrary to earlier experiences, the supporters estimations not only offers references to the transmission happening, but beyond this to the dynamic of the relationship, which is relevant for both. Healthy ties are growth orientated, encouraging, reliable, and they encourage individuality and appreciation of public spirit. That’s why we closely watch that meetings in the therapeutic setting are created like that. We elected a modified form of confrontation, which allows us to broach the other topical conflict material as a helping hand without being stuck in accusations, manipulations, appraisal and transferences. I`ll say a few words on it later. If such a process succeeds, we are in the end dealing with responsible adults, who can show each other respect at the same time as protecting the aspects of the inner child. You can learn resilience. It is the final product of a process which does not eliminate risks and mental pressures, but allows the people to deal with it in an effectively way. Or, as Albert Camus would say:

In the middle of winter I at last discovered that there was in me an invincible summer.

Appendix

Confrontation rules [D.F.]

To solve disturbances in contact the clinics and private institutes in Germany use the medium of confrontation – I do not know what this is like with our colleagues abroad. This is well designed, but puts traumatized people into unsolvable exercises. Then for these people it is particularly difficult to understand contact disorder, independent of the level of behaviour they have built up. Furthermore they are more than other clients trapped in polarizing, entanglement and introjects. With a slit change to the procedure and without the confronter expressing his full emotion, we are making good experiences. To make our procedure clear I have an example. We start with an invitation of the person who wants to confront somebody (confronter). This can, but should not be refused. Then both people concerned choose a fair distance apart. The confronter allows what is said to take effect, without being active. He gets the possibility to react after the confrontation and two procedures further in plenum. Securing is the first step and to offer an adult me. This happens with the help of three questions.

- Is or does one of you feel bodily or lively threatened through this confrontation, or feels this inside? If you are in a life threatening situation you must act – in that you fetch the police, call for help, run away or attach. From violence traumatised people often have Ego States, which experience such situations as life threatening. If this part can not be made safe the confrontation is stopped. If the answer is “no” the second question follows.
- Does one or both feel determined in his value through the other. If yes, here stands no adult me. Especially the young Ego States from traumatized people are designed for crisis and push forwards. In this case the younger me needs to be kept safe, e.g. through imagining a safe place inside one (that is known from the trauma therapy) or to a person in the group acting as nurse or nanny. The confrontation is stopped if this does not succeed. If it succeeds question three follows.
- What is it really about?

The real confrontation follows the “Revolver hand Principle”. Without adding grades suggestions and threats the confronter names a particular situation and explains what happened in his eyes. Finger pointed at the opposition. The thumb sticking up, stands for the “Higher Principle” (e.g. the group, the higher self, god…). The middle finger stands for the me expression: what has the situation set free for thoughts, feelings, body sensations and impulses in me? The ring finger informs the partner of the biographical of the reaction: I know from my life and think, feel, corresponding to these experiences so and so. Lastly the little finger shows the direction of the behaviour that normally follows, as soon as something like this happens. It follows a wish /wishes for the confronter and/or himself. It is important that wishes could come true but do not have to. The confrontation always ends with an offer of relationship in the form of at least the little finger being past from the confronter to the confronted. Should during the confrontation the safety of one party start to waver we intervene.

We have experienced workshops where we exclusively confronted experiencing confrontation as a real bonding method, because the encounter in here and now gives us the possibility to correct experiences in relationships.

The slower you go, the faster you get there! Make haste slowly!

Demonstrations of some approaching-exercises and modifications of mats with traumatized clients [D.F. und U.S].

These exercises are examples. They can each be adapted in many different ways.

We use these exercises in a variety of contexts: as preparation for a whole group, to introduce a small group of new participants individually or as an alternative to the traditional bonding mat for traumatized participants.

1. A slow approach:

The clients form groups of three people. Each trio choses their starting roles. Two of them stand facing each other of 4-6 metres apart. The third takes the role of observer and facilitator. Over time they will change places, so each of them takes on each role.

The pair then decide on their roles. The primary partner focuses on his/her awareness of his/her partner vis-à-vis. The other is available, just as the holding partner on the mat is available. This exercise begins with primary partner becoming conscious of his/her perception of the supporting partner from a distance. The next step is to notice the inner impulses and responses. To assist this process of self-monitoring, the facilitator asks questions and shares what he observes:

• What changes with each step by approaching to the partner:
in your body? in your thoughts? in your emotions?

• Is there any conflict between moving closer and and being afraid of moving closer?

• Do these experiences relate to images or memories?

In this context, clients may become more aware of their projections.
If this happens, we let him make a little step out of the line and interview him. Depending on the goal of this exercise, the reactions of the client could be expressed during the process or they could serve to guide the process on the mat afterward.
In addition to activating and resolving projections, this exercise can also help clients to get a sense of their own boundaries. This experience leads the client to/find a coherent distance from/proximity to/physical distance form the partner. Not necessarily the closest proximity is the guarantee to be in contact, but I get to encounter, if I find the right position.
For clients with dependent bonding patterns and fear of loss, we reverse the direction of this exercise. The client starts by being in contact with the partner and then moves away in order to detach and separate. What happens, what appears?
In a variation on this exercise, convergence may take place over the long side of the mat.

2. The laying on of hands - Awareness-exercise and approaching methode

Clients work in pairs for these exercise and changes the roles after one has finished the process.
First the primary partner lies on the mat in a choosen position and focuses on his awareness of his body and his breathing.

After a while he/she is invited to abandon himself/herself to an impuls to laying down his/her hand on a part of his own body if he feels the need of it. He is asked to be aware if the contact changes something in his perception. In the second step the client consciously decides where on his/her body the partner will place his/her hands.

The aims of this exercise are

- to give sufficient time practicing the awareness of the altered body perception in contact with oneself and in contact with the different touches of the partner
- helping the clients to stay in the present moment, in the Here and Now by encouraging this consciousness
- strengthening the mindfulness how does it feel to be touched in different ways
- providing realms of experiences that often leads to an emotional process

3. Five-minute hold

The client holds the position that his/her partner has chosen. The emphasis here is not about activating an emotional process. Rather the focus is on becoming familiar and learning to trust the closeness of another. Knowledge of the time limit helps to create a safe context.