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HEALING TRAUMATIC REENACTMENT: PSYCHE'S RETURN FROM SOMA'S UNDERWORLD

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Abstract

Interweaving somatic, Jungian, and psychodynamic treatment approaches with affective neurobiology, this article offers a clinical application of regulation theory to a specific case of traumatic reenactment. This integrated treatment model for patients with chronically impaired self-regulation emerges out of the author's interest in early attachment trauma, its impact on the developing brain and body, and its long-term psychological and physiological effects.[1]

Every year in October, with an almost biological urgency, a young woman I'll call Beth would descend into the underworld of tumultuous relationship loss on the anniversary of her father's death.

Freud (1961/1920) first conceptualized such behavioral reenactments as "repetition compulsion." He believed they were caused by unconscious conflict paired with repression. Jung (1960/1934), however, following Janet, recognized that overwhelming affects in the body trigger dissociation. When part of the psyche splits off to form an unconscious "traumatic complex," it behaves autonomously, sometimes like a wild animal, reenacting the trauma.

From Schore's (2002) perspective, the attachment relationship directly shapes the maturation of an infant's developing brain. Traumatic reenactment (TR) belies structural and functional deficits in the stress coping mechanisms of the right brain, resulting from early attachment trauma (pediatric PTSD) that often goes undiagnosed. Physiological contributors to TR probably include a combination of both nature (innate vulnerability) and nurture (early attachment deficits).

Eagle (1984) notes that such developmental deficits, rather than dynamic conflict, are now being viewed in psychoanalytic theory as the source of this and various other pathologies. According to Levine (1997), traumatic reenactment is the psychesoma's attempt to repair this deficit by completing the nervous system's unfinished "fight-flight-freeze" survival cycle.

This paper emerges out of my interest in early attachment trauma, its impact on the developing brain and body, and its long-term effects as manifested in a variety of psychological and physiological conditions. After a brief overview of the neurobiology of TR, I'll present a treatment vignette and commentary. Weaving together somatic and analytic approaches, this article offers an integrated treatment model for patients with chronically impaired self-regulation.

[1] An earlier version of this paper was presented at the California Psychological Association Convention in San Francisco in March, 2006, as part of a panel with Allan Schore on Regulation Theory and the Neurobiology of Psychopathogenesis.

NEUROBIOLOGICAL ORIGINS OF TRAUMATIC REENACTMENT

Beth's story illustrates how even moderately severe early attachment disruptions can have lasting traumatic impact (Bifulco & Moran, 1998). Pathological patterns of parenting are passed down transgenerationally (Main, 1999) and often those unable to provide consistent care have never received it themselves. Beth's parents, for example, were both orphaned in childhood and also suffered other unresolved trauma. Beth's mother had been placed in an orphanage at age five when her parents divorced, and the uncle with whom she later went to live sexually abused her. While Beth felt loved by her mother, she was often left unprotected by this caregiver who later became psychotic. Beth's father had never been adequately nurtured during his early childhood due to his own mother's illness and death when he was 9 years old. Emotionally unprepared for fatherhood, he became jealous of his newly born daughter and increasingly critical of her as she developed. When her younger brother was born, her father showed marked favoritism towards him. In response to her father's emotional and physical abuses Beth began to dissociate, and by age seven depersonalization had left her unable to cry. Secretly, she hated her father, and upon his death when she was ten, she feared her hatred had killed him.

Describing the raw impact of early, unsymbolized trauma such as this on a child's psyche, Kalsched (1998) uses the image of a bolt of lightning striking the electrical panel of a house. Without a human transformer, all the circuits can be blown. In Beth's case, given the unresolved disorganization in their attachment relationship, the moment of her father's death was cataclysmic, precipitating distorted reasoning, nervous system overwhelm, dissociation, and a conditioned fear response. Here, aversive stimuli (hatred and terror) were paired with a neutral stimulus (seasonal changes in temperature and light). As an adult, when dissociated procedural memories were triggered in October, Beth reenacted the original "murder" by breaking up with her current boy friend. Despite a positive work and social life, she experienced traumatic reenactment somatically in the form of severe allergies and behaviorally in the form of intrusive thoughts, flashbacks, and reenactments.

Erikson (1972/1963) recognized that mutual regulation is the vehicle through which an infant develops the trust that defines secure attachment, initially through "the ease of his feeding, the depth of his sleep, and the relaxation of his bowels." As Bowlby (1969) clarified, infant safety and survival depend on maintaining proximity to protective caregivers who are sensitively attuned to their baby's affects as signals. According to Blizard (ISSD V23, 5, 2005), "For infants and toddlers, any condition that prevents the child from accessing the parent can be perceived as life threatening."

To illustrate the contributing factors in Beth's susceptibility to traumatic reenactment, I've reconstructed a possible early life scenario to highlight the origins of her condition. Let's imagine that young Beth is five months old. She's been put to bed for the night, her parents are now having dinner, and her father is telling his wife about an upsetting incident at work that day. When their infant daughter begins to cry in the other room, her mother starts to get up to attend to her, but her father insists that she's already has been fed and they shouldn't be spoiling her.

In her crib, young Beth begins rooting around for the nipple. When she doesn't find it, she whimpers softly yet persists in her search. Several minutes pass, but no caregiver comes to comfort her. She cries more earnestly now, arms and legs flailing in frustration, but still no response. After about 15 minutes she resorts to screaming, back arched, limbs jerky and rigid, her tiny forehead dotted with perspiration. *Still* no one responds to her frantic distress. Then, terror gives way to exhaustion. Her movements go still, her voice silent. Finally, her tiny body goes limp, eyes glazed.

Freud (1961/1920) originally defined such trauma as "a breach in the protective barrier against stimuli, leading to feelings of overwhelming helplessness." At five months of age, infants used to being interactively regulated (soothed) when distressed might have been able to sooth themselves to sleep with thumb sucking or a soft toy, without being traumatized. But not here. After recurring episodes of being left without sufficient parental soothing, young Beth's nervous system has learned "fight-flight-freeze" in a flash, and for self-preservation, this conditioned fear response has been imprinted indelibly into her right brain.

Let's trace what has happened in young Beth's nervous system during the preceding vignette, using Figure 1 as a guide. When her parents don't respond to her entreaties, she immediately senses the absence of that familiar touch, warmth, and smell associated with her mother. Hofer (1984) refers to these primal sensory aspects of caregiving as "hidden regulators." Furthermore, young Beth's eyes miss her mother's familiar face; her ears miss the calming sound of her voice. This sensory information from the environment *outside* her body is received by her peripheral nervous system (PNS) and transmitted to her central nervous system (CNS) (Purvis, 2001) through a process called "exteroception" (Rothschild, 2000). All these clues signal her brain that something is desperately wrong.

Furthermore, infant Beth's racing heartbeat and muscular tension lead to an uncomfortable "gut feeling" that corroborates this mounting danger. When no one comes to pick her up, she misses the familiar bodily movements that would send signals to her vestibular, proprioceptive, and kinesthetic senses that soothing is on its way. This sensory information from *inside* her body is received by her PNS and transmitted to her CNS, through a process called "interoception" (Rothschild, 2000). These additional signals also alert her brain to the escalating danger.

As her CNS processes this exteroceptive and interoceptive input, her stress response systems activate appropriate stress hormones. These neurochemicals encode this input, then the signals are transduced and channeled back into her PNS, emerging as motor output in two different parts of her nervous system: 1) somatic and 2) autonomic (Purvis, 2001).

First, we see young Beth's somatic nervous system at work as her arms flail and her legs kick in frustration. The impulses for the contraction of these skeletal muscles are carried through the nerves of her somatic system (Rothschild, 2000). These voluntary movements are the defensive reflexes that comprise her rudimentary "fight-flight-freeze" response. Along with other behaviors and physical procedures, these movements constitute the motor output of her somatic nervous system.

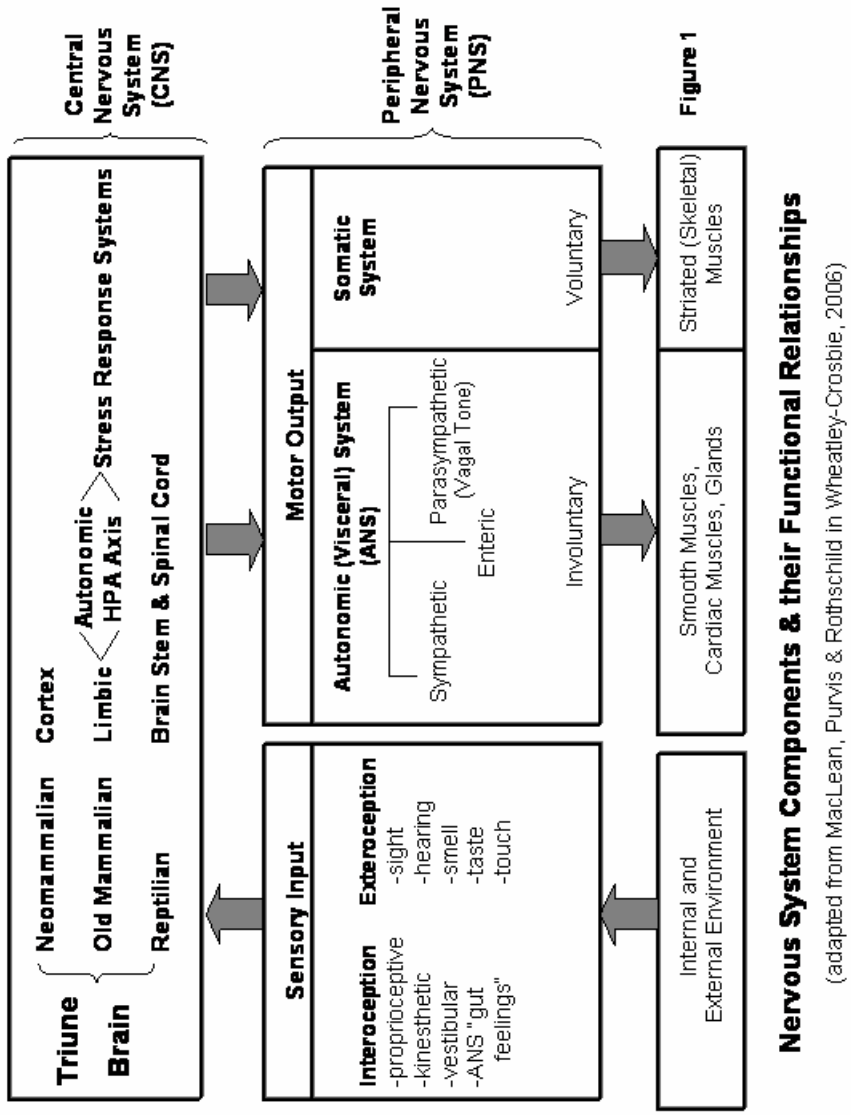


Figure 1

Nervous System Components & their Functional Relationships

(adapted from MacLean, Purvis & Rothschild in Wheatley-Crosbie, 2006)

Secondly, in infant Beth's autonomic nervous system (ANS), motor output during the "fight-flight-freeze" response entails involuntary movements in her viscera, cardiac muscles and glands. For example, among other things, the ANS directs blood flow *away* from viscera and skin *toward* the striated muscles (Rothschild, 2000), so the defensive reflexes can be expressed.

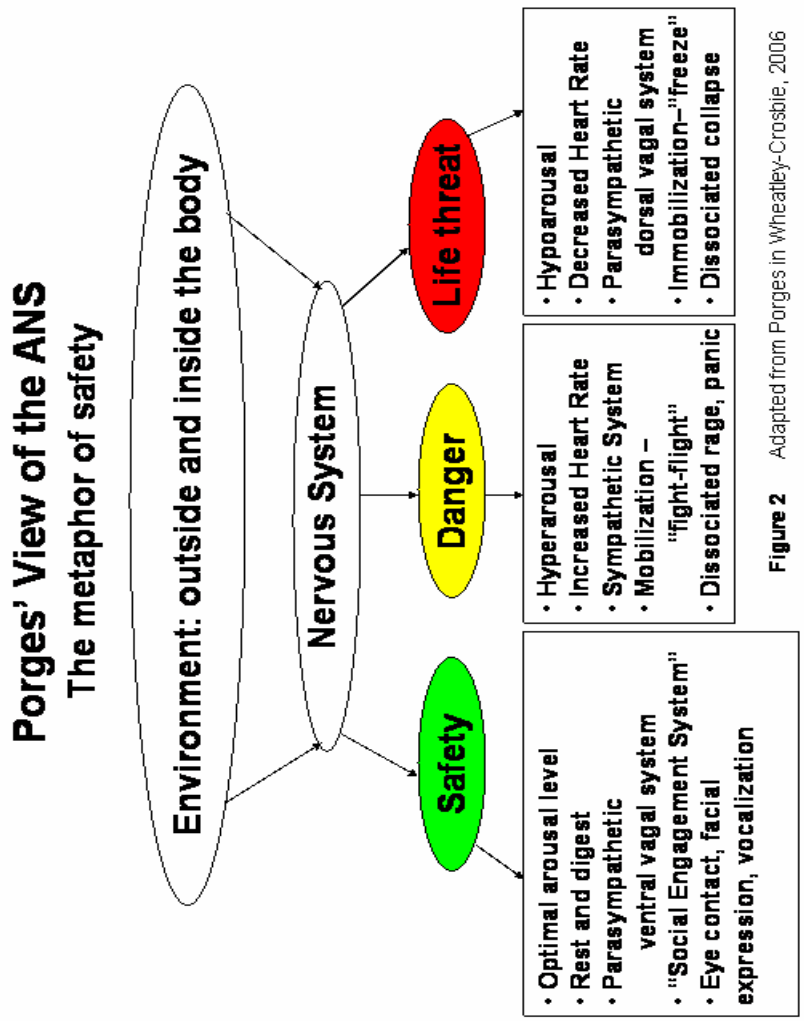
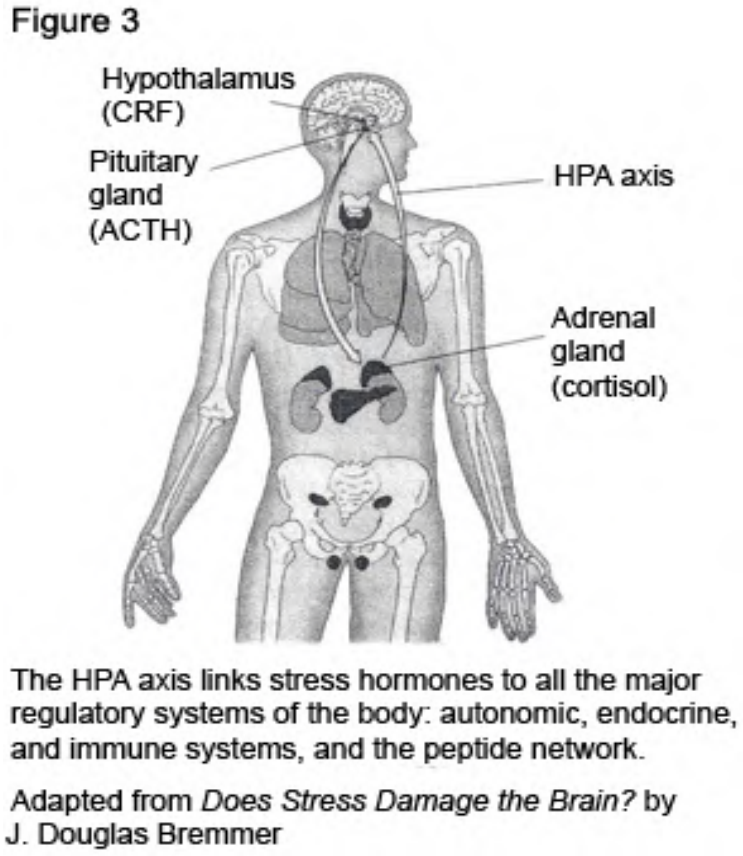


Figure 2 Adapted from Porges in Wheatley-Crosbie, 2006

When her parents do not respond to her cries, young Beth subjectively senses a shift from safety to danger. Figure 2 illustrates how her ANS adapts accordingly. According to Porges (2006), three evolutionarily based circuits regulate arousal hierarchically in the ANS. In situations of safety with an attentive caregiver, an infant's needs are met through facial expression and vocalization via the "social engagement system." But when infants are left unattended, unmet needs constitute danger. As stress hormones mobilize young Beth's "fight-flight-freeze" circuit, she starts kicking and

screaming to attract her caregivers' attention. When these strategies fail, hyperarousal escalates into dissociated panic. Ultimately, when helplessness turns hopeless, her nervous system reacts at the level of life threat. Here, the reptilian brain orchestrates an avoidance response, as endogenous opiates numb her into dissociated "freeze."



During young Beth's crisis, a complex chemical network mediates communications within and between her brain systems, stress response systems and organ systems. Figure 3 illustrates this network, which is coordinated by the hypothalamus. Considered to be the head ganglion of the ANS, the hypothalamus sets the process in motion and triggers her stress hormones via the HPA axis, a major locus of body-mind-brain communication (Rossi, 1993). Her HPA axis links stress hormones from the hypothalamus, and the pituitary and adrenal glands, to all the major regulatory systems of her body, including autonomic, endocrine, and immune systems, as well as the neuropeptide network (Bremner, 2002).

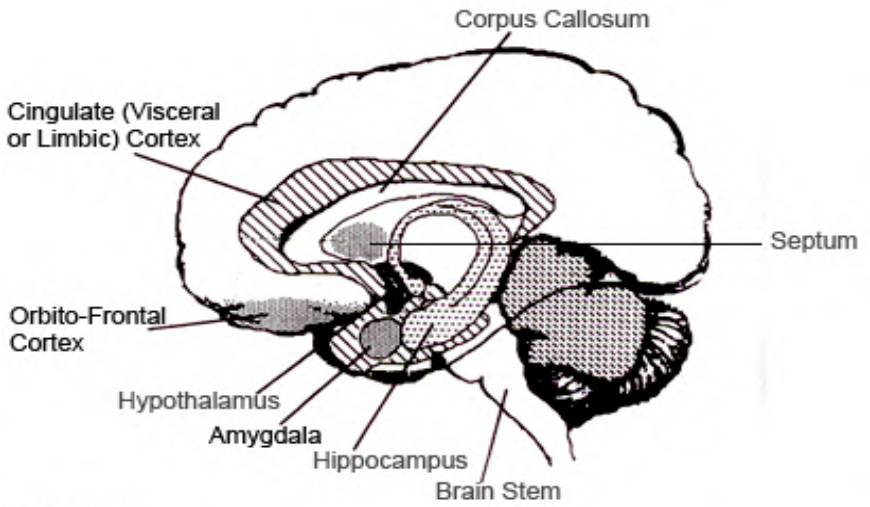


Figure 4
Limbic structures of the right hemisphere, lateral view.
From *Affect Dysregulation and the Origin of the Self* by Allan N. Schore

As illustrated in Figure 4, connections between young Beth's hypothalamus and her ANS are more deeply wired into her right brain, rather than the left (Schore, 1994). The right brain is dominant for attachment, stress coping, and bodily awareness. Her hypothalamus has two-way communication pathways with her endocrine and immune systems (Blalock, 1989), her limbic system (Guyton & Hall, 1996), and her right orbitofrontal cortex (OFC). Though her OFC won't come online till she's 10-12 months old, it will become the "senior executive" of her social-emotional brain (Joseph, 1992). During crises, the OFC will be responsible for regulating her ANS back to states of calm. During traumatic reenactment in adults, the more mature OFC shuts down, and the primitive, fear driven amygdala takes over control of brain organization.

According to Schore (1994), chronic states of dysregulation and the ongoing presence of stress hormones severely reduce neuronal growth in the infant's developing right brain. The consequence for young Beth? –future susceptibility to traumatic reenactment due to structural deficits in her right orbitofrontal cortex (OFC). These deficits cause potentially permanent abnormalities in her capacity for self-regulation. The effect?—reduced functional effectiveness of her stress-response system's ability to inhibit arousal.

The most central and far-reaching of these abnormalities is "sensitization," a heightened psychophysiological reactivity to everyday stressors (Allen, 2001). Caused by impairment in the cortical capacity for discrimination (Kolb, 1987), sensitization leaves patients unable to filter out irrelevant stimuli. Meares' research (2005) shows that individuals with sensitization feel stimuli more intensely or painfully than other people.

In our client Beth, sensitization has impacted the functioning of her HPA axis (causing her difficulty in dealing with novel stressors) and her immune system (creating heightened reactivity to foods, pollens, and environmental chemicals). Sensitization also manifests in Beth's exaggerated startle response, heightened emotionality, sensitivity to sound and light, sleep disturbance, and tachycardia (increased heart rate).

Sensitization and ongoing nervous system dysregulation form a vicious cycle of ever escalating physiological distress that contributes to traumatic reenactment. Undischarged "fight-flight-freeze" responses in the body are analogous to depressing a car's accelerator and brake pedals simultaneously. According to Levine (1997), these survival cycle responses must be completed and released from the body-mind-brain if traumatic reenactment is to be healed.

DISSOCIATION AND MEMORY IN TRAUMATIC REENACTMENT

As we saw earlier, young Beth's first impressions of "fight-flight-freeze" come through her senses, as they perceive the growing sense of arousal and disorganization in her body. Yet at the tender age of five months such unbearable bodily sensations are not yet translated into words. Rather, they remain in the somatic unconscious (Jung, 1998/1930's). Consequently, these overwhelming sensory experiences cannot be processed or stored as conscious or explicit memory by her hippocampus (see Figure 4). Instead, these implicit, procedural memories are encoded in the form of sensory fragments (van der Kolk, 1996) that are stored subcortically in a variety of different memory systems: the amygdala, brain stem and other primitive neural systems. Mediated by stress hormones and seared indelibly into her developing right brain, these unconscious traumatic bodily memories last forever (LeDoux et al, 1989).

When infant Beth's cries fail to influence her caregivers, mounting despair leaves her feeling invisible, undeserving of love. During infancy the primary protective mechanism against such unbearable stress is dissociation, which Putnam (1997) refers to as "escape when there is no escape." Schore (2006) describes dissociation as the disintegration of vertical right brain limbic and autonomic circuits.

Functionally, dissociation leaves young Beth unable to integrate what's happening in her environment with what's happening in her body. She may be terrified she's fragmenting into pieces, dissolving into space with no orientation, or falling forever. Perhaps she can no longer even sense any connection to her own body. These terrifying impressions form the basis of her dissociated, unconscious traumatic memory.

As young Beth falls into dissociative collapse, she enters a dark, inchoate state. All she knows is that something is terribly wrong. Since no one is there to help, all she can conclude is that something must be wrong with *her.* As Winnicott (1992/1958) understood, infants suffering such unthinkable anxieties experience not frustration, but threat to their sense of "going-on-being." Paradoxically, in an effort to preserve the child's existence, the mind splits the personality apart. The goal? –organizing the

protection that should have been provided by the primary caregivers.

Segal (1981) suggests that splitting is the mind's way of differentiating "good" from "bad." According to Bion (1967), the primitive mind splits by attacking the links between thinking and feeling, thus producing a state of fragmentation. Feeling is experienced and expressed through the body. When infant Beth is overwhelmed with feelings, her primitive mind decides that these feelings and the body they are housed in are "bad," and any connection to them must be severed.

As her mind splits off from her body, young Beth's nascent self is shattered, and we witness the birth of a "traumatic complex" (Jung, 1960/1934). As Jung (1912) observed, ongoing fragmentation keeps the intensity of the original terror from ever reaching full consciousness. Consequently, the emotional significance of the complex remains hidden, while its terror continues to be reenacted in adulthood.

As outlined earlier, such fragmentation is possible because the brain stores its recall of experiences in separate memory systems (LeDoux, 1996). Since each of these systems processes the same traumatic memory in different ways, dissociated aspects of experience, and thereby dissociated aspects of self, are able to coexist. According to van der Kolk (1989), dissociated traumatic memories can trigger behavioral reenactment when held in striated muscles and somatic reenactment when held in smooth muscles.

Furthermore, traumatic memories are "state dependent," meaning they are linked via stress hormones to the psychophysiological state of arousal encoded at the time they occurred (Rossi, 1993). Though dissociated trauma continues to remain outside conscious memory, if a similar psychophysiological state arises years later, these state-dependent memories can be retriggered, appearing in the form of intrusive experiences or flashbacks. These sudden somatosensory experiences seem immediately and palpably real, even though the original event is long past (Briere, 1992).

Sensory intrusions of this kind reflect states of psychophysiological "sensitization." Fear conditioning has contributed to the development of this sensitization, precipitating overgeneralized responses to traumatic or even neutral stimuli. For example, in Beth's adulthood even subtle anger in another person's voice or facial expression could leave her suddenly disoriented and uncomprehending. At stressful moments like this Beth's "father complex" would suddenly overtake her. Then, unbearable bodily memories from the past—nervous system hyperarousal that arose originally in reaction to her physically abusive father's angry voice and frowning face—would suddenly inundate her present reality. Such sensorimotor intrusions are expressions of the somatic unconscious (Jung, 1998). Their palpable presence confirms, "every complex has a body" (Schwartz-Salant, 1989).

Scaer (2001) hypothesizes that the brain has an arousal/memory circuit fueled by unresolved "fight-flight-freeze" and conditioned fear responses. This arousal/memory circuit triggers two processes: 1) sensitization (as mentioned earlier, heightened reactivity to *external* stressors), and 2) kindling (heightened reactivity to *internal* stressors). In kindling, internal stressors consist of dissociated traumatic procedural memories that arise unconsciously and continually reactivate the individual's nervous system, preventing its return to complete rest. Both sensitization and kindling are contributing factors in the above example of traumatic intrusion as Beth's father complex is triggered.

TREATMENT IN TRAUMATIC REENACTMENT

Treatment of TR requires two primary mechanisms: 1) regulation of affects and "fight-flight-freeze" responses in the body, and 2) reintegration and symbolization of dissociated self-states in the psyche. Within the safe enough container of the transference-countertransference relationship, therapists help patients re-experience trauma in the present moment, this time in manageable doses. As complexes are triggered, bodily activation can be accessed and interactively regulated. Then, bodily and behavioral suffering can be translated into meaningful feeling and linked to imagery through play. Only then can symbolic processing of traumatic experience, rather than concrete reenactment of it, begin to unfold. Gradually, attachment wounds are healed, positive new internal working models develop, and destructive patterns of TR are eclipsed by the emergence of a more integrated self.

Even within a safely regulated container, the nervous system of a traumatized patient can easily become overactivated. During one session, Beth arrives tearful and terrified that her boyfriend will leave her. Complaining of an intractable knot in her solar plexus, she reports a panic attack the day before. As she becomes caught in the underworld of her hopelessness, Beth fears "going crazy" like her mother and succumbing to another round of catastrophic October loss. These traumatic intrusive thoughts illustrate Winnicott's (1974) notion of "fear of breakdown."

Tuning into Beth's body language, the therapist notices a paradox. Her slumped posture suggests a helpless child-like state that could easily shift into parasympathetic collapse. On the other hand, her solar plexus tension indicates a state of sympathetic hyperarousal. Prioritizing the client's physiological disorganization rather than narrative, the therapist suggests that Beth might feel more comfortable if they first ease the pain in her solar plexus. Beth immediately frowns, begins coughing, and exclaims, "It's not a *pain*! That's not me! It's more like bracing against a storm."

As Winnicott (1974) reminds us, trauma retires to the past only after being experienced *directly* in the present. Patients' reactions to therapists' inadvertent misattunements can be an important mechanism for recapitulating early trauma in the transference/countertransference. Bromberg (2003) and Bucci (2003) agree and add, in accordance with LeDoux (1996), that in order for dissociated experience to become symbolized in conscious awareness, the following key steps are necessary.

As early trauma is revisited, the body and the amygdala must remain calm enough for sufficient working memory to be available for the following tasks: 1) visceral, sensory and motoric elements of early trauma (which are nonconscious and dissociated) have to be activated and consciously felt in the present moment, as they were here with Beth; 2) a mental representation of this physiological activation must be created; and 3) a mental representation of the self as agent in the present must also be created.

Yet, physiological activation related to catharsis of early trauma triggers arousal in the brain stem and evokes "fight-flight-freeze" physiology. In traumatized patients, such catharsis can lead to nervous system disorganization and potentially damaging retraumatization, unless it is carefully regulated. "Fight-flight-freeze" states constitute "bottom up" brain organization. In such dysregulated states, intense bodily urges and affects shut down the OFC, and the fear driven amygdala dominates brain organization. Interactive regulation is needed to restore calm to the autonomic nervous system so the OFC can come back online. Then, "top down" brain organization is restored, and memory is again available to influence present brain processes (LeDoux, 1996).

Beth's "fight-flight-freeze" response during the therapist's earlier misattunement is shown in Figure 5. Her dysregulated nervous system is illustrated by the dotted line shooting up past the boundary of the optimal arousal zone. If left unregulated, Beth's hyperarousal would later drop down below the optimal zone into hypoaroused "freeze." On the other hand, if Beth receives sufficient soothing (nervous system regulation), her sympathetic and parasympathetic systems can return to fluctuating within the optimal range, as illustrated by the curving solid line.

The therapist realizes that Beth's earlier rejection of the word "pain" could be a dissociative strategy. Compartmentalization is one way for traumatized patients to distance themselves from unbearable affects. With Beth, for example, the present misattunement may have triggered an unconscious procedural memory associated with her father's painful abuses in the past. Initiating an interactive repair, the therapist uses non-interpretive interventions, such as clarification, mirroring, acknowledgment, and validation (Holinger, 1999), until the agitation in Beth's body and tone of voice begins to subside.

Levine's (1997) Somatic Experiencing (SE) method provides a model by which therapists can attune to the dysregulated nervous systems of their traumatized patients and restore them to a state of organization. This method integrates Gendlin's (1981) "felt-sense" with Schore's (2006) regulation theory. While clients tell their stories, therapists track moment-to-moment shifts in posture, facial expressions, sounds, gestures and other movements, as well as changes in skin color, musculature, and breath in their clients' bodies as well as their own.

As if exploring a waking dream, the therapist helps Beth bring her conscious awareness more fully into her body. Together they track specific subjective details of the sensation in her solar plexus —for example, its dimension, sensory quality, movement, texture, and temperature. With the help of her imagination, Beth creates a mental representation of this dissociated experience, describing it as a dark "storm" of hot swirling energy about the size of a grapefruit. Afterwards, she reports that she is slightly calmer. In other words, paradoxically, the simple act of bringing attention to a disorganized area of the body can restore some level of organization there (Levine, 1997).

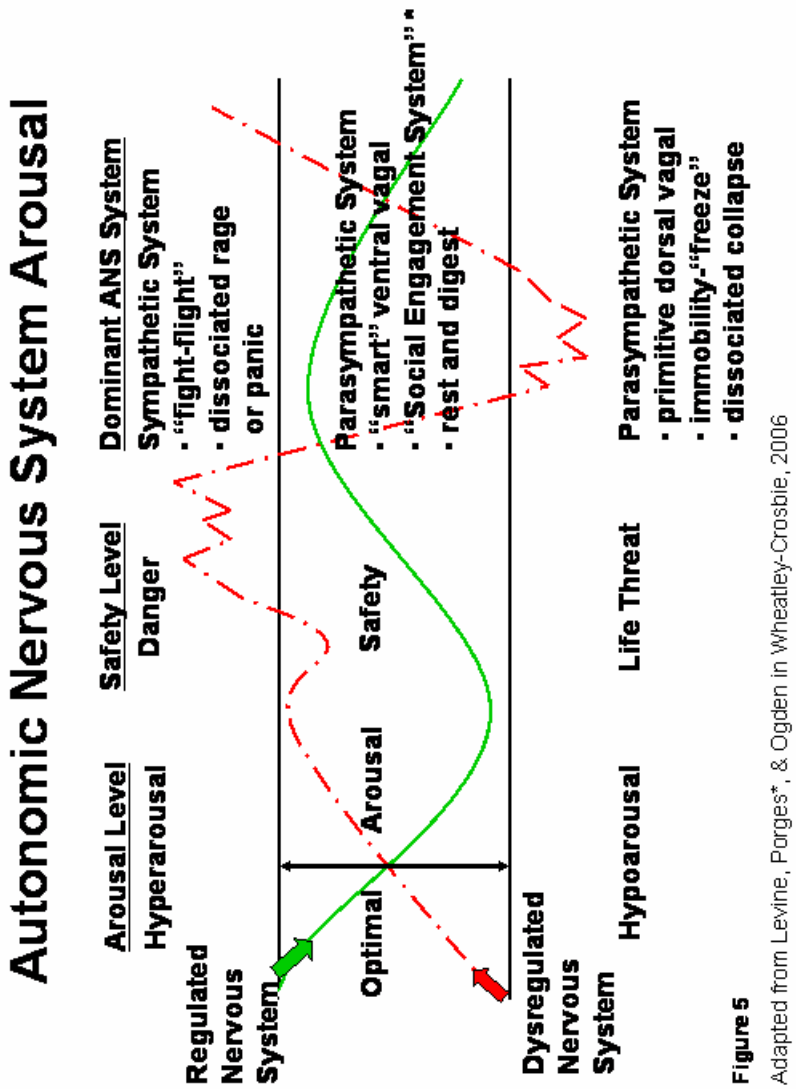


Figure 5
Adapted from Levine, Porges*, & Ogden in Wheatley-Crosbie, 2006

Nevertheless, Beth's susceptibility to panic, sensitization, and kindling indicate the need here for further nervous system stabilization. After asking permission to work further with Beth's body, the therapist fosters a deeper experience of the client's embodiment (Aposhyan, 2004) by suggesting that Beth might place her own hand on the tightness in her solar plexus. Beth does so, and during the silence that follows, the therapist offers gentle encouragement as the tempo of Beth's breathing pattern begins to

slow down. Inviting the client to allow her attention to sink more deeply into her solar plexus via the weight and warmth of her hand, the therapist guides the patient toward a more restful parasympathetic state.

After a period of silence the therapist asks how this touch feels, facilitating integration of the client's sensory and affective experience. When Beth says it's soothing, the therapist invites other soothing associations. Beth remembers a languorous summer vacation on a Greek island, and the therapist encourages her to savor these sensory memories: lying on warm sand by the Mediterranean, the salty smell of the sea, the sound of waves lapping against the shore, sand granules between her toes, and the sun's heat cooled by a soft breeze. Gradually, Beth's breathing flows more easily, and the seemingly intractable tightness in her solar plexus eases to half its former intensity.

Having settled down in response to this interactive regulation, Beth is once again available for "top down" reflective function. Using Beth's image of the dark swirling storm, the therapist facilitates what Krystal (1998) calls "desomatization." Here, Beth consciously differentiates bodily sensations, such as solar plexus tightness, from affects, such as abandonment terror. Following Levine's (1999) SIBAM model, the therapist helps Beth "connect the dots" as it were between dissociated elements of sensation, imagery, behavior, affect and meaning, toward an integration of self.

Then the therapist suggests gently to Beth, "Maybe, when your boyfriend doesn't call, your body remembers the stark terror of infancy, when your *needs* were left unmet by your parents." Beth cries softly in response. When interventions match the developmental level at which the patient currently presents, a deeper level of trust is fostered. Beth's disorganized regression to the pre-object relations level of development (Kumin, 1996) is met appropriately through this reconstruction. The therapist validates Beth's early abandonment terror and acknowledges how its unconscious procedural memory may be embedded in her present panic, precipitating its traumatic reenactment.

The trauma of early abuse and neglect often leads to a breakdown in the capacity to mourn (Levy & Lemma, 2004). Beth's tears reflect the conscious mourning of a loss of basic caregiving that occurred before she was old enough even to know what she was missing. By acknowledging the importance of Beth's tears, the therapist facilitates the grieving process that is crucial to resolution of early childhood loss.

Later, to foster a return to homeostasis, the therapist invites Beth to find an image that's opposite her helpless state of panic. The client remembers a recent dream: she's standing in a meadow on a sunny day, bare feet in the warm dirt, watching a sunflower bobbing in the breeze. Following Woodman's (1985, 1982, 1980) inspiration, the therapist encourages Beth to enter the realm of play, bringing the sunflower image inside the wounded place in her body.

A few minutes later Beth describes the sunflower's seed face as comprising her entire torso and head. Giggling slightly, she adds that its petals are her hair. The therapist responds playfully, "Oh, of course-- anybody can see that!" and they laugh together. Beth describes a sturdy stem that will keep her grounded amidst a storm. The therapist validates her new sturdiness, encouraging her to savor it, and Beth responds with tearful gratitude. As Schore (2003) reminds us, a psychobiologically attuned caregiver not only

minimizes negative affect but also maximizes positive affect.

During the developmental shift from merging into autonomy, playful relaxation and the neurochemistry of joy arise naturally out of the shared state that Winnicott called (1971) "potential space." Working with embodied imagery fosters the development of symbolization, a capacity often lacking in traumatized individuals yet essential for mature selfhood. As Beth's trust of her therapist grows, a symbol of her supportive caregiver develops in the form of an "internal working model" (Bowlby, 1969)

There is a moment of silence after Beth's play with the sunflower. Then, suddenly, the patient frowns, takes a sharp inhalation of breath and exhales forcefully, after which her shoulders go into a slump. When the therapist comments on the client's body language, Beth reports having heard a derisive inner voice spewing, "This is stupid," accompanied by a feeling of shame and the familiar pressure to break up with her boyfriend. Here, the therapist notices that a traumatic complex (Jung, 1960/1934) has been triggered.

Rather than engaging first at the level of verbal content, the therapist prioritizes interactive regulation at the bodily level. Together therapist and client observe that Beth's defensive reaction includes hypervigilance and bodily constriction, indicating the return to a "fight-flight" state. They also notice that the shame accompanying her bodily slump suggests a state of collapse associated with the "freeze" state.

Casement (1985) describes patients for whom the experience of "feeling better" can serve as a signal affect that stimulates further anxiety and nervous system hyperarousal. This linking of two such seemingly discreet events is an example of what Levine (1999) calls "overcoupling." Overcoupling can be a common occurrence in traumatized individuals when a conditioned fear response is triggered in response to kindling (heightened reactivity to *internal* stressors, such as unconscious procedural memory). In this instance Beth's fight-flight-freeze response may have been inadvertently triggered as the result of an unconscious memory of an earlier experience of safety that was immediately followed by a traumatic experience.

As if tracing a figure-8 image, the therapist helps Beth "pendulate" (Levine, 1999) back and forth between sympathetic arousal and parasympathetic rest. Gradually, the level of her activation is "titrated" (Levine, 1999) until homeostasis is restored. Then, after revisiting the connection they made earlier between bodily tightness and feelings of terror, client and therapist explore the traumatic complex that has been constellated.

Ferenczi (1955/1933) proposed a model for how these complexes take shape: before the ego solidifies, one part of the personality *regresses* to an infantile state, while another part *progresses*, becoming precociously mature. Winnicott (1988/1965) described the progressed part as a "pathological mind-psyche" that has split off from the body. Though originally intended to serve as "protector" for the weaker part (Kalsched, 1996), this dissociated introject "identifies with the aggressor" (Ferenczi, 1955/1933) and repeats the original parental abuse intrapsychically. Acting in true autoimmune fashion, this dissociated self-state loses "self-tolerance" (Kalsched, 1998). Shaming Beth's vulnerable self by referring to her creative play as "stupid," the protector/ persecutor takes control by

banishing the emotions—and relationships-- that cause this younger aspect of herself to become overwhelmed.

Having already titrated the patient's nervous system hyperarousal, the therapist wonders about possible precipitants for the activation of Beth's complex. Here Beth is able to reveal her frustration about the therapist's misattunement earlier in the session. As they work with Beth's anger, the client discovers that the protector/ persecutor's angry shaming has essentially turned the anger she initially felt toward the therapist back against *herself*. With the therapist's prompting, Beth rallies an emerging capacity for self-care. "Stop calling me stupid!" she barks in rebuttal to this pathological mind-psyche. Setting limits with its persecutorial tone, Beth is autoregulating the self-hatred endemic in early trauma. Afterwards, the client reflects upon the protector/persecutor's controlling behavior: "This shaming part of my mind only makes things worse. I need to *let this mind go."*

The therapist notices the musicality in Beth's last phrase and mirrors it back, encouraging her to express the same feeling rhythmically with sound rather that words. Beth begins, "*Hmm…mm…mmm… mmm. Hmm…mm…mmm…mmm*." The therapist then notices that, in accompaniment to her voice, Beth's arms are making rhythmic gestures. Nobel laureate Sperry (1981) wrote, "The brain is first and foremost an organ for action." According to Darwin (1998), "The goal of emotion is to effect physical movement and regain a state of physical equilibrium." In this moment Beth's brain has transduced her newly discovered feeling of empowerment into bodily action.

At this point the therapist has a visceral, somatic countertransference reaction to Beth's arm movements and decides to reveal it, saying excitedly, "When your arms released into movement, my belly released with a burp!" Sidoli (2000) wrote, "An analyst must be genuine and real in the relationship with the patient, unafraid to display emotions appropriate to the situation." Initially, Beth is unaware her slumped posture has shifted and her defensive reflexes have sprung into action. Thrilled about the client's achievement and eager to affirm it, the therapist immediately recognizes that the burp seems to punctuate this point.

In other words, somatically resonating with the client's bodily truth, the therapist's burp reflects a spontaneous recognition that Beth has completed the "fight-flight-freeze" cycle that must be resolved if trauma is to be healed. The therapist then clarifies that Beth's arms seem to be pushing away what she *doesn't* want and pulling toward her what she *does* want. Here the therapist validates that Beth's arms are taking transformative action. As the client pushes away those negative aspects of the inner persecutor that do not feel protective, she differentiates defense from self vis a vis her own unmet survival needs.

The therapist's body is an essential instrument for empathic psychobiological attunement (Dosamantes, 1997). In response to nonverbal messages from clients, therapists may react in a variety of unconscious somatic ways: visceral responses, nervous system activation, changes in rate or quality of breath, onset of headache or other pain, and postural shifts. Awareness of internal bodily reactions in both patient and therapist provides fundamental clues about what's happening in the transference/

countertransference relationship in the present moment.

Beth is able to see herself more fully through the therapist's eyes as a result of this somatic self-disclosure. In the process of absorbing the image of what the therapist has reflected back about Beth's bodily actions, the patient completes the last of the steps for symbolizing dissociated experience: acquiring a mental representation of herself as agent who can reflect upon the here-and-now. Once higher reflective function rests upon the solid foundation of a well-integrated self inhabiting a well-regulated body, the role of unconscious conflict and repression in traumatic reenactment (Freud, 1961/1920) can be explored more effectively.

CONCLUSION

When early abuse has become a self-fulfilling prophecy, the traumatized client's desperate need for healing can motivate a heroic journey. In the dance of interactive regulation that emerges between therapist and patient, movement pendulates between "then" and "now," rupture and repair, terror and courage. As an alliance of self-states consolidates, the traumatized patient moves toward "psychosomatic indwelling" (Winnicott, 1974) and the wholeness of being one self while, at the same time, many (Bromberg, 1998). Carrying the tension of the opposites (Jung, 1956/1916), an integrated self comes to face and embrace its true suffering, and this courageous act paradoxically transforms hopelessness into healing. Then, a coherent narrative of the journey can unfold as psyche returns from soma's underworld.

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Biography

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