Trauma and TA psychotherapy – notes by Dave Spenceley TSTA

Trauma - the inner injury, the internal rupture and splitting which occurs as a result of external events. It is what happens within and not without that is the trauma. Trauma leads to a suppression and a splitting of the self which prevents us from growth, experiencing and living in the present.

Trauma means wound – and it is how we are wounded and deal with our wounds which shapes our behaviours and social norms, our feelings and our thinking about the world around us, impacting on our significant relationships.

While PTSD grabs the headlines, in psychotherapy we are only occasionally presented with a client who could be diagnosed with PTSD, however many of our clients present with the current life problems of clients that seem to be disconnected from the impact of long-term trauma. The chronic childhood abuse over long periods of time, a thousand cuts, a thousand days of neglect or bullying, the violence in the family, the death of a pet, a loved parent, a sibling or an important attachment figure.

PTSD: is categorised as one of the "trauma and stressor disorders" in the DSM5:

Only a small percentage of those presenting for counselling and psychotherapy that have been impacted by trauma will have lived through one time - specific events that are experienced as life threatening, which can lead to the diagnosis of post-traumatic stress disorder (PTSD).

However, many clients will present with symptoms of PTSD without fulfilling the criteria for a formal diagnosis. For many even the connections between the traumatising events and their lived experience will be lost, confused and unrecognisable to them.

Criterion A (1 required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):

- Direct exposure
- Witnessing the trauma
- Learning that the trauma happened to a close relative or close friend
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B (1 required): The traumatic event is persistently re-experienced, in the following way(s):

- Unwanted upsetting memories
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (1 required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):

- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (2 required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):

- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (2 required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):

- Irritability or aggression
- Risky or destructive behaviour
- Hypervigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.
Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).
Criterion H (required): Symptoms are not due to medication; substance use or other illness.

Two specifications:

1. **Dissociative Specification**. In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
    - Depersonalization. Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
    - Derealization. Experience of unreality, distance, or distortion (e.g., "things are not real").
2. Delayed Specification**.** Full diagnostic criteria are not met until at least 6 months after the trauma(s), although onset of symptoms may occur immediately.

TA Psychotherapy for those with PTSD – It is important to differentiate between those who were functioning well, successful in their relationships and chosen life prior to a relatively recent specific life-threatening trauma and those suffering long term impacts of often forgotten or suppressed and possibly chronic trauma in childhood or adulthood. Many clients who had experienced a specific traumatic event can do well with brief psychotherapy.

With these clients I explore what it is they are looking for in psychotherapy and usually they say in effect that they want to return to living, not necessarily the same life exactly as prior to the trauma, however they want to feel alive again and to engage and be active in their lives again. They have no desire to explore their childhoods or to do in depth therapy, they wanted to deal with the trauma, find a strategy that worked for them and to then get on with their lives. They would never have consulted a psychotherapist if it were not for the impact of the traumatic event. Of the following cases briefly described I saw a few for only two or three sessions and used dissociative approaches with them, with the aim of enabling them to separate from the traumatic event, while also creating a narrative to make sense of their experience. For some this is sufficient.

I have worked this way with train drivers following suicide incidents. A factory manager and one of his staff following a horrific accident on the production line.

One executive fell from a sailing boat. He had set off with colleagues for a fun, a few beers on an adventurous team building day. While hanging on to his life jacket he realised that nobody had seen him fall and he was convinced he was drowning, he had no clear recollection of how he was saved, and woke up in a hospital bed, with no idea how he got there.

One client in a serious car accident while driving to work, remembered setting off for work when suddenly another red car coming directly towards him, he swerved into a tree and was trapped. He does not know for how long, it seemed an eternity in pain and blackness, which was followed by a vague awareness of flashing lights and a terrible sound of the sirens. The next thing he remembered was his friend crying next to him in a hospital ward with various infusions and bandages. There was no coherent story of what had actually happened to him, nor what his injuries were.

He was adamant that he did not want any questions from me about his childhood. Of course, this simply intrigued me more and I became increasingly interested, but he was not going to enlighten me.

Therefore, I used a technique which I learned initially many years previously in Christian counselling in which we encourage the client to visualise the scene as a film in which Jesus or an angel protected them. By the time I was working with this client I was no longer believing in magical gods, and so I changed the image so that he created a safe protector who would travel with him which of course is also quite wonderfully magical. It is worth saying that given the right circumstances this is an extremely effective technique, and with all the variations I can say it works well – in fact I don't recall using this technique and it not having the desired outcome.

This technique is also used in NLP and a version of the technique is described in a 1988 TAJ article called Wounded Kid Therapy, however rather than using the cinema image which is used in the article I usually invite the client to imagine being in a helicopter or flying on a magic carpet. It does not matter what the fantasy is, only that it provides a way of lifting the person out of the experience, moving them from being in the experience to observing themselves.

Dissociative - magic carpet technique for use with specific traumas, unhooking the feelings associated with the trauma. These will only "unhook feelings and experience" associated to events. These techniques are based on magic and use the "child" imagination we all have.

The Magic Carpet, a guided visualisation. The therapist is the movie director instructing the client what to do.

- Enter into the story -

1) Tell the story as recalled, with as many details as possible. Include sounds sights, smells, and feelings.
2) Start the story in a safe place, (reading at home etc.) and end the story well after the traumatic event, and only when once again in a safe secure place.

- The change and escape to safety -

1) Tell the story again; associated into the story… be in the story, "I am driving along when I see a dog run in front of me…"
2) At the moment when you start to be aware of being scared, sit on the magic carpet (Get into a Harry Potters broom stick, helicopter, space rocket / angels / gods back, whatever sounds and feels good for the client.)
3) Sitting safely on the carpet, notice how safe the flying carpet is – it is magical you can't fall off. It keeps you safe. The carpet leaves the scene and flies you way up high, "go high enough so that you are no longer afraid, and the event is unfolding below you… you can see you driving along etc." Ensure safe feelings and security, drink a milk shake, eat chocolate, whatever feels good for the client. Music is playing, soothing, jazz, rock – whatever the client likes.
4) The events unfolding down below are happening – but as if on a TV screen, you are enjoying your flight. Keep flying until all the events have unfolded in the story.
5) Then fly on your magic carpet to the safe place --- then slowly descend, landing safely in a safe place with those who care and love you, those who will enjoy being with you.
6) Now step off the carpet and say high to those who are with you.
7) Let them know that you are now safe.
8) When they know you are safe get back on the magic carpet and fly back over the scene, as if watching the movie run backwards, and land again in the original safe place.
9) Repeat this process at least three times, ending finally in the new safe place.

- Ecological check…
- Ask about the event... they should now be dissociated from the trauma and be experiencing safe feelings.
- One in the new safe place describe what you are now experiencing, feelings, and what you are looking forward to doing with the rest of your day.

Additional things you can do is to invite changes in what NLP terms sub-modalities: add / change sounds / music / colours. Make it a black and white movie, let the client be creative.

Repeat in further sessions if need be: The client in the car accident used this fantasy in one session, and came back for the second, in which he startlingly told me, I am cured – thank you and he left. I did say to him that he could always return if he wished – but he was not interested. With others, for example the man who fell overboard, he came back for two further sessions, however on the third he informed me that he had returned to work, and all was well.

I have used this same technique with other problematic situations, such as people being afraid of dogs, going to the dentist, going on buses etc. On one occasion I used it effectively with a client regarding their fear of dogs. She was very happy until a few weeks later she returned to ask to repeat the film, only this time with a barking dog. – We had forgotten the first time round to have the dog's bark!

However, these approaches have only limited value with clients who have suffered long term neglect, repeated abuse, and bullying.

Clients often come expecting short term / brief therapy however they then engage in long term psychotherapeutic work as it is clear that their recent experience was in fact the final straw which had broken their resilience.

One such client told me that two years prior to seeing me he had been through a brief course of CBT that had been of no help, and a friend of his had recommended I was effective and a few sessions with me would fix him! He told his story as if it was a radio news report. He had heard violent screams and shouting in the neighbouring house, however rather than intervene he had turned the TV up louder, hoping to cover the noise. When the police knocked on his door to question him, he tried to hide. After questioning by the police, they informed him that his neighbour had been murdered by her husband. He then collapsed, and has since that time felt guilty, incapable of sleep or of getting on with life. Each time he heard loud noises he panicked. As I listened and worked to form the therapeutic relationship with him, it quickly became apparent that his decision to turn the TV up louder was a consequence of a childhood where he had tried to cover his ears to avoid hearing the frequent violence between his parents. The recent trauma opened up old nightmares from his childhood, and he clearly needed long term psychotherapeutic work. Brief interventions and techniques were not sufficient for him, despite his idealising and magical transference towards me.

A first responder had worked with two therapists, one using CBT and the other a local pastoral counsellor, he had been absent from work for over two years by the time he was referred to me by a colleague. Eventually after many months of struggle and doubt he came to see me. One day during a shift he had become terrified, panicking and rigid with fear. He believed that he was going to be doubly incontinent and could not face returning to his ambulance. He describe collapsing by the ambulance and being taken home by a colleague. By the time we met he was deeply ashamed, believing that he was possibly dementing, or going crazy. He did not understand what had happened and could make no sense of his experiences.

We worked together for many months before he could comfortably return to work, in a different role. He had needed to change his life and the expectations he was making of himself and in order to do so he needed to work through many issues related to himself and others. He described how he was the child that had "always kept the family safe and together", and now he could not keep any of his patients safe. After seeing me for a few months he confessed that prior to the collapse and panic he was experimenting with a same sex extra marital affair. This seemed to me to be extremely significant, however he had made no connection to his panic or collapse. It appeared to me that not only was he overwhelmed by the repeated horrors in his daily work, he, had also stepped far outside of his family role. The fears of incontinence and his shame had meant he had quickly ended the sexual affair. It was many months before he could begin to make connections and to face his life as it really was. Very gradually he found a new way of relating to himself and others at which point, he was ready to resume living again.

This example shows just how extremely important it is to form safe trusting relationships, seeing the client as a whole person, with all their life experiences, and not just the presenting obvious problem. It seems to me that his extra marital affair had moved him far from his safe base and that the combination of this and the daily traumas had eventually overwhelmed him.

Another client, that had been referred inappropriately by his family doctor for brief therapy. He was driving when there was a major traffic accident, his wife and two children died, while he escaped with no injuries. He had no idea what had caused the accident, and despite the evidence he blamed himself. For this client it was imperative to support him through his grief work while dealing with the specifics of the traumatic traffic accident. During the sessions it would not have been possible to separate the two processes.

This horrific story was vividly alive for me. At the time I was a relatively young parent, with two young children, and I frequently drove through the junction where the accident had happened. While working with the client's trauma and grief I had to deal with my own fears and sadness in supervision and psychotherapy. Supervision and personal therapy are essential for all psychotherapists and counsellors working in this field.

Carl Rogers described the foundations of all healing therapeutic work as being: Genuiness, accurate empathy and unconditional positive regard-

TA Psychotherapy and the core models of TA:

Berne's frame for TA psychotherapy provides the foundation – with the goals of promoting spontaneity, intimacy and autonomy in relationship reflecting a life position of OK – OKness. Believing we can all change, are responsible for our feelings, thoughts and behaviours. The EATA handbook describes TA psychotherapy's goal as healing the hurt of the past to live freely in the present, and TA counselling is described as promoting autonomy

It is trauma in the early relationship that causes disruption and emotional pain, and it is also through relationship that these disruptions can be healed: The core models of TA that are used to understanding the lived experience of trauma: Script / racket system / protocol analysis – ego state analysis – the passivity material, discounting, and symbiosis – impasse theory.

Script questions used to explore big T and small t traumas, when the client knows that they lived through traumatic events:

1) What traumatic childhood and / or adult events occurred which may have been one off or a repetitive.
2) How does did the client make meaning and experience themselves, others, life during the traumatic experiences.
3) When remembering / recalling / talking about those events how does the client experience themselves – others – life?
4) Life, death and insanity, what decisions did the infant / child / teenager / adult make about life, death and insanity and how are they manages in the client's script?

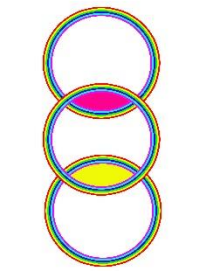
If the client does not recall or describe past events as trauma, ask the same questions about their childhood experiences as well as current experiences which are disturbing them. When asking these questions, it is important that they are asked within a caring, attuned inquiring relationship, completing the script matrix or racket system is not simply a task to fulfil. The therapist is listening for the words used, the language, the non-verbal communication, that is how the client is telling their story. How the clients tell their story is at least as important as the story and reveals the client's experience.

Berne described the pre-verbal development of the script narrative as the script protocol, and it is this protocol which provides the foundations on which we build our lives. Christopher Bolas a UK

psychoanalyst describes these “unforgettable and unknowable” pre-verbal experiences using the term the “unknown thought.”

Childhood trauma is unforgettable and yet unrememberable and is therefore unavailable to cognitive analysis and talking therapy. This has a profound effect on the understanding and practice of psychotherapy aimed at resolving the long-term impact of trauma. It is through experiencing the transformative psychotherapeutic relationship over time that can lead to healing. At the centre of TA psychotherapy, we understand that it is the therapeutic relationship, with “eye to eye” contact which heals. The requirement for eye to eye, affectively attuned relationships was described in detail by Allun Schore in his book on affect regulation and the origin of the self.

During the early work then the therapist is developing the therapeutic relationship, getting to know, and listening carefully to the client’s story, seeking to understand the client’s experience. If there are specific problems identified, the initial goal will be to find strategies to deal effectively with the current problem. This first stage of therapy is exploring and resolving 1st degree impasse(s), strengthening the Adult ego state boundaries. Which Berne described as decontamination, gaining social control and symptom relief, differentiating between archaic Parent or Child beliefs, feelings, behaviours and thinking and what is appropriate in the here and now – which is Adult, here and now functioning.



Contaminated Ego State Diagram
Eric Berne

In the picture the Parent and Child ego states overlap with the Adult. The person believes they are functioning appropriately in the here and now – however they are actually acting on archaic beliefs and experiences. The Adult is “contaminated” by Child or Parent.

While decontamination work, and finding coping strategies is taking place the process of deconfusion has begun from the initial formation of the therapeutic relationship. The therapist is noticing and interested how you live, what you believe about yourself, others, and life. How do you think and feel? How do you make decisions about what you do and don’t do, how are you in the therapeutic process? The focus gradually moves from events outside of the therapy room to the lived experience in the therapeutic encounter.

The goal of TA psychotherapy, healing the hurts of the past in order to live freely, autonomously, spontaneously, intimately in the present. Transforming relationships with yourself, others, and the world around you, which enable you to manage and contain your future life.

This can be understood as exploring and resolving embodied 2nd and 3rd degree impasses. Which Berne described as deconfusion leading to script cure. I and many TA practitioners describe and understand the process as creating a healthy and functional script narrative giving meaning and direction in life.

This phase of psychotherapy is therefore focussed on deconfusion of the Child ego state and constructing a healthy functional Parent ego state.

During the whole process techniques and approaches from the TA however are used, with the goal of enhancing the empathically attuned exploration of experience with the therapeutic relationship. To repeat it is the relationship which heals.

A central premise in TA psychotherapy is that psyche and soma are indivisible in healthy cognitive and emotional functioning and that direct attention to cognitive, emotional, and bodily experiences must be actively included within the therapeutic project. As humans we are an embodied, thinking & feeling living experience, in relationship to ourselves, others and the world around us. All emotions / thoughts / actions / reactions and relationships are embodied. Much of our psychological organization, experience and wholeness comes from our physical sense of being in the world.

Touch is a normal relational / human expression of contact from one person to another, therefore, the question is not should we touch – rather it is how and when and why we touch. If we decide not to touch – what is the reason and intention in withholding the touch.

Erskine describes the importance of inquiry, attunement, and involvement and 8 relational needs. Every person requires a relationship in which the other person is reciprocally involved.

8 relational needs described by Erskine:

1. Security
2. Valuing
3. Acceptance
4. Mutuality
5. Self – definition
6. Making an Impact
7. Having the other initiate
8. Expression of love

In his work Gabor Maté describes the importance of expressing anger which has the function of defending and expressing personal integrity. In my view this is only a part of the story, appropriate expression of all emotions serve the same function. Core emotions are energising, life affirming, so one therapeutic goal is for the client to express their emotions. (emotional fluency)

- Joy – to celebrate the current experience.
- Sad – energy to deal with loss.

- Angry – energy to change an aspect of the current experience.
- Scare / terror – energy to escape and avoid a threat. Horror is experienced as observer of an external event which we are helplessly doomed to observe.
- Surprise – shocked by a current unexpected event.
- Disgust – revulsion regarding an external object / event.

TAJ articles –

1) **October 2006 – Jo Stuthridge: Inside Out – A TA model of trauma**.
A relational model of trauma based on TA – the Adult is used to create a narrative of self / a coherent sense of self identity. Trauma interferes with this integrative capacity, creating excluded ego states and a disorganised self. The experience of abusive caregivers is internalized in a series of toxic Parent / Child ego states. This inner world informs the child' view of the external world. This then leads to transferrential enactments that reinforce a traumatic script narrative. Therapy develops the Adult capacity to create a coherent narrative that allows the client to move from enacting to reflecting.

2) **July 2012 – Cristina Caizzi - Embodied Trauma:**
Using the sub-symbolic mode to Access and change script protocol in traumatized adults.
Traumatized adults develop somatic symptoms which are bodily expressions of deep psychological issues resulting from trauma at the protocol level with special attention to those who have survived torture.
The neurological responses to torture are described, leading the survivors of torture to not function from Adult, rather responding to perceived dangers at the level of script protocol, involving somatic, sensory, reactions. This is revealed in therapy in sensations and emotions therefore psychotherapy is through a relational experience and is not a cognitive experience. A relational psychotherapeutic approach is used to find words, to describe and name their emotions and sensations and what these states mean for their current lives. This leads to distinguishing between past trauma and the present.

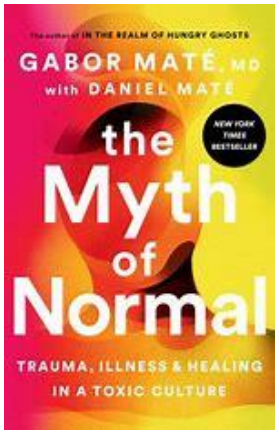
3) **Nov 2013 – Edward T Novey – Combining Ego state theory and relational approaches to TA in working with trauma and dissociation.**
The treatment of dissociation that originates in childhood trauma exploring ego state theory and relational theories of trauma. Using a combination of relational TA and ego state theory provides flexibility in sessions to address intra-psychic and interpersonal processes.

4) **2016 – Kerrylea Sampson – Shared Trauma: a time to think.**
Shared trauma, when the therapist and client are both going through the unavoidable traumatic experience, such as in natural disasters in which the therapist and client are sharing the same trauma. The authors experience of earthquakes in New Zealand are described. When faced with trauma adults may dissociate, but this does not result in split off traumatized states, rather a

permanently altered state of self. With all that is familiar being called into question, leading to a sense of a collapsed sense of self.

- Although our professional demeanour has value, it is our basic humanity, our honest questioning, our awareness of personal limitation, and our cantered presence that facilitate the deepest change in our clients.
- Our intellectual knowledge must translate into our capacity to be embodied.

The Myth of Normal –



Gabor Maté and Daniel Maté - explores the relationship between individual psychological trauma and society

The book is very readable, of too long, and he is easy to listen to.

(See various online video presentations.)

Gabor Maté's book and his presentations fit well within the frame of refence of TA: "scripts we unwittingly and inexorably live out" following trauma, which could have equally been written by Berne.

Trauma - the inner injury, the internal rupture and splitting which occurs as a result of external events. It is what happens within and not without that is the trauma. Gabor describes how trauma is at the centre of the process which leads to detachment. Trauma leads to a suppression and a slitting of the self which prevents us from growth, experiencing and living in the present.

Trauma means wound – and it is how we are wounded and deal with our wounds which shapes our behaviours and social norms, our feelings and our thinking about the world around us, impacting on our significant relationships.

Society is toxic in many ways which are taken for granted, which cause trauma. Maté provides numerous case examples, personal stories and analysis of society. He also describes healing processes and exercises, which I found to the be the weakest section of the book which at this point seems limited and shallow.

Maté is well known for promoting the use of psychoactive substances in controlled situations which he describes in the book. I have reservations about this approach, which seems to me to be contrary to the approach of psychotherapy which is about and self-discovery integration. It seems to me that this

is seeking an externally induced, magical solution to an internal problem which is similar to the desire of many who seek relief through many and various drugs, prescribed, and non-prescribed which are often addictively used for recreation and soothing purposes.

Peter Levine: Shocks can alter a person's biological, psychological and social equilibrium in such a way that it dominates all other experiences. Levine uses the graphic phrase "the tyranny of the past". The conscious verbal, explicit memory is only the tip of the iceberg below are all the implicit experiences and memories which are held with no words to describe the experience.

Pierre Janet: Traumatic memories are held in automatic actions, reactions, sensations, attitudes, which are then replayed in visceral sensations.

Maté quotes child development research: "The architecture of the brain is constructed through an ongoing process that begins all the health, learning and behaviour that follows. The interaction of genes and experiences literally shapes the circuitry of the brain and is critically influenced by the mutual responsiveness of the adult-child relationship, particularly in the early childhood years".

Bessel Van der Koch – (The Body Keeps the Score) states that all trauma is preverbal, using a process described as subverbal encoding:

1) The actual trauma was experienced pre-language development.
2) When the trauma occurs after the development of language the trauma is processed by the brain and the body in ways which do not involve language.

Trauma which occurs preverbally to infants is multi-faceted and varied, it can be direct violence and neglect in the family. It can also be as a result of the impact of natural disasters, or of societal issues such as racism and poverty and conflicts such as wars. Trauma leads to a wide range of disorders, however the links between the trauma and presented disorder can often remain invisible.

Major traumatic events are often called "capital T traumas", which underly disorders which are labelled as mental illness. They also increase the vulnerability to physical health, and inhibit healthy functioning, for example the "switching in" of genes is impaired, a process described in detail by Allun Schore in his books.

Maté states that despite all the evidence, big T traumas barely register on the provision of services, while small t traumas are not even causing a blip.

Capital T traumas – are inflicted on the vulnerable and dependant person / infant.

- Child abuse - physical / sexual / neglect.
- Violence in the family.
- Destructive and angry divorce.

- Death of a parent or sibling.

Small t trauma – Long lasting and persistent wounding of the infant / vulnerable person. Less memorable, and yet unforgettable hurts that are more prevalent misfortunes in childhood.

- Bullying within social groups and within families.
- Harsh and yet of repeated comments from parents and important others.
- Lack of a loving, nurturing, nourishing, safe home with loving contact with parents and those around the infant.
- The lack of emotionally attuned relationships, with no secure attachment available. Literally nothing happened; when the child needed a parent to care and to respond. The child experiences being motherless / parentless.

There is always a continuum of experience, and it is the fracturing of the self and the fracturing of the relationship to others and the world that is the essence of trauma, not the events which lead to the fracturing.

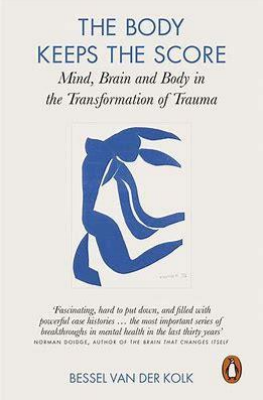
This fracturing leads to clients, experiencing a distorted view of the world and themselves. Often saying that they are observers of themselves, and of life, while not experiencing being alive and yet living. They are often experiencing shame, which I describe as being the experience of self-disgust or self-loathing, while believing that "there is something wrong with me".

Traumatic events, when experienced as life threatening after childhood can also be incredibly significant and may change the client's experience of themselves or others and their place in the world. The world may change from being safe to being dangerous.

Healing principles: "four A's" and five compassions:

1) Authenticity – something lived and experienced, embodied – noticing and expressing your experiences, he describes that when being authentic new choices emerge in place of old pre-programmed dynamics.
2) Agency – the capacity to freely take responsibility for our existence – and uses the familiar phrase "response ability" in decisions regarding living our lives.
3) Anger – the expression of anger in the "moment" is a healthy defence of the self – of the persons boundaries, physical and emotional integrity. –
4) Acceptance – This is how things are: "allowing things to be as they are."

5) Ordinary human compassion: – Interpersonal compassion by essence is being involved with the other and involves empathy.
6) Curiosity and understanding: Everything exists for a reason and that reason matters.
7) Recognition: We are in this together.
8) Truth: Pain and hurts are not the enemy, when healing trauma, the experience of pain and hurt is going to be experienced.
9) Possibility: There is more to each of us than the pre-conditioned presentations we make to the world, we have the possibility of the new, authentic life.



The body Keeps the Score – Bessel Van der Kolk.

Brain, Mind, and Body in the Healing of Trauma –

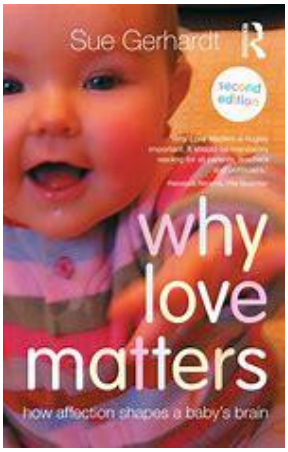
This book is built on the authors experience and understanding of the impacts of trauma.

There are excellent sections on the contributions research has made on our understanding of the impact trauma has on neuro functioning for example. Describing in depth neuro functioning.

There are sections on various approaches to treatment, I especially enjoyed the description of EMDR a simple and the best brief description of EMDR I have come across. It reminded me of summer therapy intensive when I was working together with a TA colleague who used EMDR with clients immediately after their sessions with me, with the goal of integrating therapeutic learning.

There is a delightful and sadly short section on the importance of touch as the most elementary tool we have, and the importance of body psychotherapy. Starting on page 251 with the importance of supportive relationships and stating that he encourages all clients to engage in body work. “You can’t fully recover if you don’t feel safe in your skin”.

However - I was disturbed by the first client’s story, in the first chapter on lessons learned from Vietnam. The client described a horrific trauma suffered in the war. However, the victim then describes taking a very violent revenge: murdering women and children, raping women. This story is told with the perpetrator as the victim, without noting that this was itself a horrific war crime that went unpunished. There seems to be an acceptance that this is what happens in war.



Why Love Matters - Sue Gerhardt – describes in a very readable form why love is essential to brain development in the early years of life, particularly to the development of our social and emotional brain systems.

Why love matters is an easy – at least relatively easy book to read has made this a must go to read for psychotherapy trainees, social workers and psychologists – when books reach across disciplines in this way it means they have important things to say

- "The foundations are built during pregnancy and in the first two years of life... This is when the social brain is shaped, the emotional style and emotional resources established"
- "Small differences in the foundations make huge differences in the outcome"
- "The poorly handled baby develops a more reactive stress response and different biochemical patterns from a well-handled baby: Our minds emerge, and emotions are organised in engagement with others, not in isolation"
- "Babies of agitated mothers may stay over aroused and have a sense that feelings explode out of you, there is nothing to be done about it. Well managed babies come to expect a responsive world"
- "Researchers have found that the most difficult and irritable babies do fine when with responsive parents, no such thing as a difficult baby which is largely the perception of the parent."

Difficult parents:

1) Neglectful; the child develops a depressed way of interacting, less positive feelings and their left brains are less active, perform less well on cognitive tasks and are insecurely attached.
2) Intrusive; mother may be depressed but is also angry even if covertly, and is hostile to the baby, but is also overly involved with the baby. The child is insecurely attached in an avoidant or chaotic way.

Parents … bring the baby into the emotional world by identifying feelings and labelling them. Children of depressed parents are 6 times more likely to be depressed themselves as adults.

The Brain; Neuroscience and psychotherapy: The brain more than doubles in weight in the first year of life, this growth is experience dependent: As are the emotional, cognitive and verbal development and their related growth and development areas within the brain. Schore describes how

the most important and vital aspect of relationship is in looking at faces, the open eyes, including the large pupil size, large, dilated pupils are signs of pleasure and interest and invite a positive response.

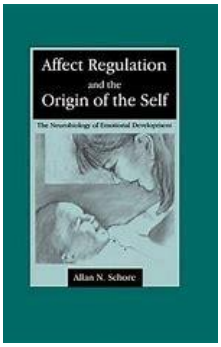
The baby smiles more, and the mothers care more: "The reciprocal and sustained, face to face gaze transactions" this directly effects the development of the brain and the release of neuroendocrine, which bring pleasure and directly stimulates the growth and development of the brain. However, negative looks and interactions stimulates the production of cortisol which in turn prevents the development of the brain.

"The volume of the brain in general and in particular the size of the prefrontal cortex (which is so important in controlling and self-calming) is directly affected by abuse or neglect, the earlier the abuse or neglect the smaller the brain volume"

The prefrontal part of the cortex has a unique role; linking the sensory areas of the cortex; thoughtful responses to emotions, within the emotional and survival areas of the sub-cortex, which are responsible for our emotional intelligence. This area, the orbito-frontal cortex develops after birth and does not mature until toddlerhood. This development is directly related to the baby's experience of his / her interaction with people, it is experience dependent. The first area to develop is the social brain and is highly responsive to social experience.

Experience with the Romanian orphans who were left without contact with adults has shown that they have a virtual black hole where this area of their brains should be. There is little hope of full recovery or of developing this part of the brain.

"**Mentalising**… The capacity to recognise others minds, develops as a result of healthy attachments, people who have a borderline disorder grow up avoiding his because it would involve recognising the parent's lack of love or hatred"

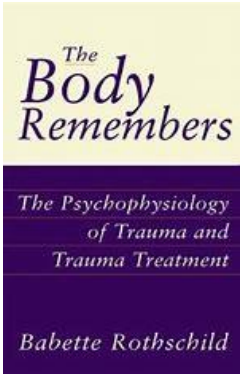


Affect Regulation and the Origin of the Self – Allun Schore

Published in 1994, this book helped transform psychotherapeutic approaches due to the increased awareness and understanding of child development and the role of relationships and emotional regulation in the formation of the self.

Drawing on research in neurobiology and infant research Schore proposes that an infant's affective interactions with the early human social environment directly and indelibly influence the post-natal maturation of brain structures the will then regulate all future socio emotional functioning… the first relationship, with one's mother acts as a template as it permanently shapes the individual's capacity to enter all later relationships.

Early postnatal development represents an experiential shaping of the infant's genetic potential. … 70% of the cerebral cortex's genetic content is added after birth."



The Body Remembers – Babbette Rothschild – A discussion of how the brain organises the bodies response to stress and trauma, describes the importance of tailoring every trauma therapy to the particular needs of each individual client.