

Healing Traumatic Wounds Using a Brief Therapy Model

Brief Therapy Conference
December 7, 2018

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Brief Therapy for Trauma?

- How **do** we address the consequences of child abuse and neglect, domestic violence, war, disaster, terrorism, or sexual assault **BRIEFLY**?
- The assumption that trauma requires a much longer course of treatment stems from a very real dilemma: the impact of **traumatic experiences creates a more complex hierarchy of treatment challenges**
- And these challenges are not resolved by encouraging clients to their experiences into words. **Trauma-related symptoms stem not from the failure of memory but from the inability to forget!**

Why is it difficult to remember and impossible to forget?

"Under conditions of extreme stress, there is failure of . . . memory processing, which results in an inability to integrate incoming input into a coherent autobiographical narrative, leaving the sensory elements of the experience unintegrated and unattached. These sensory elements are then prone to return when . . . activated by current reminders."

Van der Kolk, Hopper & Osterman, 2001

Sensory elements without words = implicit memory

- Brain scan research demonstrates that **traumatic memories are encoded primarily as bodily and emotional feelings** without words or pictures—detached from the event
- These implicit memories do not “carry with them the internal sensation that something is being recalled. . . . **we act, feel, and imagine without recognition of the influence of past experience** on present reality.” (Siegel, 1999)
- “**Emotional memory** converts the past into an expectation of the future. . . [and] **makes the worst experiences in our past persist as felt realities.**” (Ecker et al, 2012, p. 6)

Fisher, 2015

Implicit memories take many different forms

- Intrusive emotions disproportional to the stimulus:** fear, anger, shame, dread
- Thoughts the predict threat or failure,** as well as intrusive, contradictory, or ruminative thoughts
- Impulses:** to run, to hurt the body, drink or drug, hide under the bed, avoid going out
- Somatic sensations:** dizziness, pain, heaviness, floating, tingling, numbing, ‘noise’ in head, loss of hearing or vision
- Attachment symptoms:** yearning for contact, loneliness, fear of abandonment, mistrust, approach-avoidance behavior

Fisher, 2015

Nervous System Adapts to a Threatening World

Hyperarousal-Related Symptoms:

Impulsivity, risk-taking, poor judgment
Chronic hypervigilance, anxiety, ruminations and compulsions
Intrusive emotions, flashbacks, nightmares, racing thoughts
Compulsive behavior providing temporary relief: addiction, self-harm, suicidality

Sympathetic Hyperarousal

Parasympathetic Hypoarousal

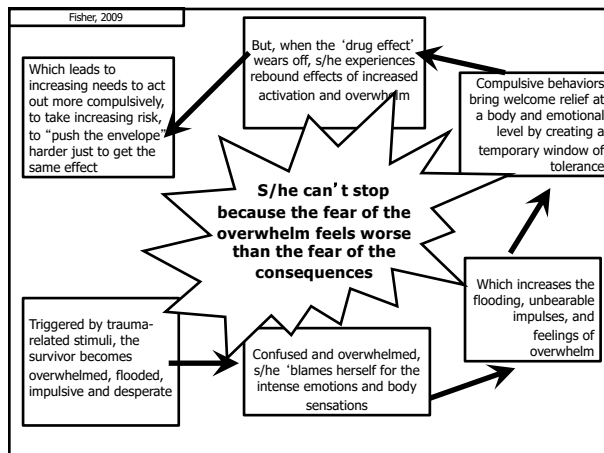
Hypoarousal-Related Symptoms:

Flat affect, numb, feels dead or empty, “not there”
Cognitively dissociated, slowed thinking
Cognitive schemas focused on hopelessness
Disabled defensive responses, victim identity

Ogden and Minton (2006);

Fisher, 2006

*Siegel (1999)



Compulsivity and Trauma

Thus, addictive and self-destructive behaviors arise not as a pleasure-seeking strategy but as a **survival strategy**:

- *To self-soothe and self-regulate*
- *To numb the hyperarousal symptoms: intolerable affects, reactivity, impulsivity, obsessive thinking*
- *To "treat" hypoarousal symptoms of depression, emptiness, numbness, deadening*
- *To combat helplessness by increasing feelings of control, to combat loneliness through 'safe' connection*
- *As a way to function or to feel safer in the world*

Fisher, 2011

Addictive Behaviors and Self-Regulation

- **Eating disorders:** under-eating or restricting induces numbing effects accompanied by increased energy. Binging lowers arousal, while purging results in a temporary increase in arousal followed by profound hypoarousal
- **Overeating:** induces numbing with relaxation, spaciness, and loss of energy and motivation, resulting in curtailed activity
- **Self-injury:** self-harm produces both an adrenaline and endorphin response in the body, increasing energy and feelings of power and clarity and also buffering the pain
- As in substance abuse, **prolonged use of these behaviors leads to tolerance: more and more is needed to achieve the same effect**

Fisher, 2003

Core Assumptions of an Integrated Trauma and Addictions Model

- For individuals with histories of trauma, **any addictive behavior begins as a post-traumatic survival strategy** aimed at regulating autonomic arousal and keeping traumatic memory at bay
- Dependency results from the fact that these compulsive behaviors require continual increases in dosage to maintain their effectiveness: **eventually, use becomes misuse, and misuse becomes dependency**

Fisher, 2007

Core Assumptions of an Integrated Model, continued

- Sobriety or abstinence only addresses the safety and addictions issues.** Because these behaviors have been a post-traumatic survival strategy, new challenges now arise
- The client now faces new risks of post-traumatic flooding,** autonomic dysregulation, increased impulsivity in other domains, and relapse as a desperate attempt to self-regulate
- **Treatment must address the relationship between trauma and self-destructive behavior:** the role of the behavior in “medicating” traumatic activation, the origins of both in the traumatic past, and **the reality that recovering from either requires recovering from both**

Fisher, 2007

Traumatic experiences and
compulsive behavior are difficult
to address at a cognitive level

*“Words cannot integrate the
disorganized sensations and
action patterns that come from
the core imprint of trauma.”*

van der Kolk, 2004

Sensorimotor Psychotherapy

•Sensorimotor Psychotherapy is a body-oriented talking therapy developed in the 1980s by Pat Ogden, Ph.D. and enriched by contributions from Alan Schore, Bessel van der Kolk, Daniel Siegel, Onno van der Hart, Ellert Nijenhuis, and Kathy Steele.

•**Sensorimotor work combines traditional talking therapy with body-centered interventions that directly address the somatic legacy of trauma.**

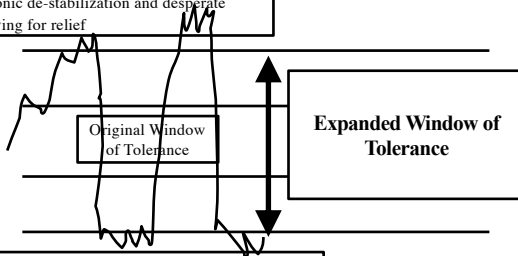
•By using the narrative only to evoke the trauma-related bodily experience, **we attend first to resolving how the body has “remembered” the trauma**

Sensorimotor Psychotherapy Institute

Ogden, 2002; Fisher, 2006

To Address Trauma Disorders, the Window of Tolerance Must Expand

Hyperarousal: over-activation creates chronic de-stabilization and desperate craving for relief



Hypoarousal: numbing, ‘deadness’ and passivity contribute to need for eating disorder to either shift or maintain this state

Ogden and Minton (2000)

Therapy must deliberately challenge, rather than reinforce, conditioned patterns of response

To challenge the patterns without further dysregulating the client, the therapist uses two interventions:

•“The first is to ...**observe, rather than interpret**, what takes place, **and repeatedly call attention to it**. This in itself tends to disrupt the automaticity with which procedural learning ordinarily is expressed.”

•“The second therapeutic tactic is to engage in activities that **directly disrupt** what has been procedurally learned” and create the opportunity for new experiences

(Grigsby & Stevens, p. 325)

Judith Herman's (1992) Three-Phase Model of Trauma Treatment

PHASE I: Safety & Stabilization: Overcoming Dysregulation

- *Establishment of bodily safety and control of the body*
- *Establishment of a safe environment*
- *Establishment of emotional and autonomic stability*

PHASE II: Coming to Terms with Traumatic Memory

Since "remembering is not recovering", it is only necessary to come to terms with the traumatic past, rather than trying to uncover all details.

PHASE III: Integration and Meaning-Making

As the survivor's life become increasingly consolidated around a healthy present and a healing self, the trauma gradually becomes farther away

Adapted from Herman (1992)

To Stabilize, Frontal Lobe Inhibition Must Be Reversed

"In order for the amygdala to respond to fear reactions, the prefrontal region has to be shut down. . . . [Treatment] of pathologic fear may require that the patient learn to increase activity in the prefrontal region so that the amygdala is less free to express fear."

LeDoux, 2003

A Brief Therapy Approach

- **A phase-oriented treatment approach is a perfect fit for brief therapy—IF** we use an intermittent therapy model with brief therapies for each phase of recovery with time to integrate and consolidate the work between treatments.
- **Six-to-10 sessions for Phase One, 6-10 sessions at Phase Two, and 3-6 sessions for Phase Three is a perfect trauma treatment model** when coupled with 'homework' during the intervals between treatments
- In fact, an intermittent brief therapy model might work **better** for some traumatized clients than long-term therapy because it prevents a complicated traumatic transference

Fisher, 2018

What are we therapists trained to do?

- **Listen** empathically
- **Communicate** unconditional **positive regard**
- **Adhere to the principle of neutrality**
- **Be non-directive:** empathically follow the client's lead
- **Interpret** client experience and encourage insight
- **Foster connection to painful past experiences** to understand present conflicts and symptoms
- **Facilitate direct connection with affect**
- **Encourage the expression of affect**, especially in therapy
- **Discuss and interpret transference phenomena** Fisher, 2013

What should the trauma-wise therapist do?

- **Take an active role in treatment:** listen empathically but also ensure that clients don't get overwhelmed, offer psycho-education, help client relate to their experience mindfully instead of flooding
- **Offer unconditional acceptance of the individual** by re-framing whatever the client or culture has pathologized
- **Teach the patient how to modulate and titrate affect** before encouraging 'sitting' with overwhelming emotions
- **Teach the patient that feelings and sensations are the best guides for interpreting past reality**, but mindful reality-testing is a better guide to understanding present reality
- **Avoid interpretation of transference** but offer education about trauma and its effects on the experience of relationship Fisher, 2013

"The therapist's role is both intellectual and relational, fostering both insight and empathic connection. Kardiner notes that 'the central part of the therapy should always be to enlighten the patient' as to the nature and meaning of his symptoms, but the same time 'the attitude of the physician in treating these cases is that of the protecting parent. He must help the client reclaim his grip on the outer world. . .'"

Herman, 1992, p. 137-138

Phases of a Brief Therapy Approach

■ PHASE ONE TASKS

- **Psychoeducation to empower the client** and reduce shame by creating a different way to relate to the trauma. **Education helps clients appreciate how they survived instead of how they were victimized.**
- **Teaching mindfulness skills** to ‘wake up’ the frontal lobes, increase self-awareness, and allow observation of patterns that “feed” unsafe behavior
- **Building resources for modulating autonomic arousal:** since de-stabilization reflects autonomic dysregulation, the antidote is learning skills to better self-regulate.

Fisher, 2011

Psychoeducation

- **Offer a “crash course”** on understanding trauma symptoms and behaviors as evidence of how the client survived
- **Normalize the feelings/behaviors** that have been sources of shame, and reframe them **as ingenious attempts to cope**
- **Label the symptoms as “symptoms”:** poor judgment and impulse control (“I can’t help it”), self-loathing, self-neglect
- **Increase awareness of post-traumatic triggering** and habitual triggered survival responses: “getting” the logic of trauma decreases shame/increases understanding of cause-and-effect
- **Encourage curiosity and compassion:** “That makes sense.” “I get that . . .” “Of course you feel trapped. . .” “Maybe that feeling of hopelessness is a memory of how it felt then.”

Fisher, 2018

Psychoeducation doesn’t require trust . . .

“Though the traumatized patient feels a desperate need to rely on the integrity and competence of the therapist, she cannot do so, for her capacity to trust has been damaged Whereas in other therapeutic relationships some degree of trust can be presumed from the outset, this presumption is never warranted in the treatment of traumatized patients. . . .”

Herman, 1992, p. 138

Facilitating Mindful Awareness

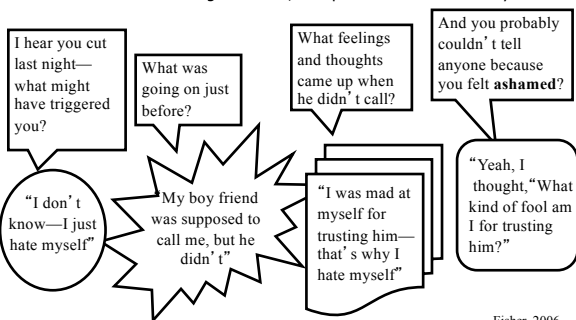
- **Mindfulness in therapy depends upon the therapist becoming more mindful:** slowing the pace of thinking and talking, refraining from interpretation, encouraging neutral observation, helping the patient begin to focus on the flow of thoughts, feelings, & body sensations
- **Mindful attention is present moment attention.** We use “retrospective mindfulness” to bring the client into present time: “As you are talking about what happened then, what do you notice happening inside you now?”
- **Curiosity is cultivated because of its role as an entrée into mindfulness:** “Perhaps by binging and purging, you were trying to help yourself get to the wedding. . . .” Fisher, 2009

Mindfulness Skills

- “**Notice** what just happened right now . . .”
- “Let us be **curious** about that. . . .”
- “Let’s **just notice what happens inside** when you talk about your wife. . . .”
- “**Notice the sequence:** you were home alone, then you started to get agitated and feel trapped, and then you just **had** to ‘get off.’ How could you tell you ‘had’ to do something?”
- “**What happens inside** when you remember that?” Fisher, 2004

Connecting Symptoms to Triggers

In the context of client’s having cut herself, therapist tries to evoke curiosity:



Connecting Symptoms to Triggers, cont.

Therapist continues to ask mindfulness

When you had that thought, what feelings came up?

How overwhelmed were you?

Well, cutting triggers adrenaline so the body feels calmer—you were just trying to get control back, huh?

Do you want me to show you something else to do that will help you feel less overwhelmed? It won't work as well, but at least it won't get you in trouble!

"I wanted to kill him, and I wanted to kill me!"

Completely overwhelmed—I couldn't stand it"

"But now I'm feeling stupid, and my arm is killing me!"

"Sure... I'd like to survive this weekend!"

Fisher, 2006

Re-framing the Symptoms: 'Entraining the Positive' [Fosha]

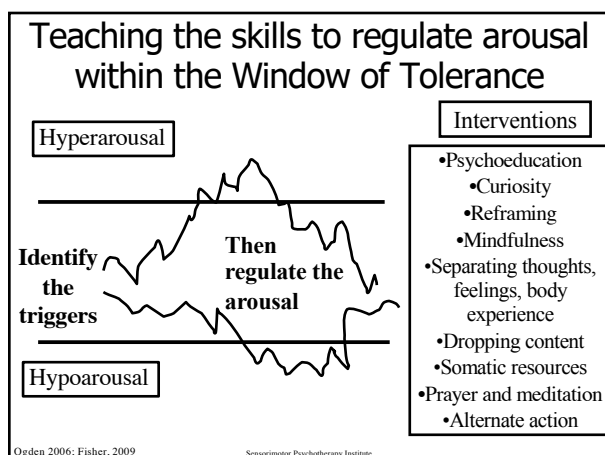
- Re-framing asks: how might the symptom be adaptive or have adaptive intent?** E.g., smoking pot before going to work might alleviate anxiety; restricting food intake as a way to numb overwhelm might help the client go out on a date
- All compulsive behaviors capitalize on body chemistry:** "Of course, acting out gives you relief! Between the adrenaline and the endorphins, of course you feel better." "Sadly, sex, drugs and rock 'n roll soothe anxiety better than medication."
- Reframing allows us to celebrate "survival resources"** (Ogden, 2000) which challenges habitual beliefs of inadequacy and defectiveness and also allows the therapist to 'befriend' acting out and addicted parts of the personality

Fisher, 2006

How does mindfulness contribute to trauma treatment?

- To be observant and curious requires activation of the prefrontal cortex. **Whereas traumatic activation inhibits frontal lobe activity, mindfulness engages it**
- Re-engagement of the prefrontal cortex increases access to good judgment and management skills**, increasing the ability to inhibit impulsive behavior and re-regulate
- Rather than responding to traumatic triggers with impulsive action, **mindful awareness also allows the client achieve a little more distance from overwhelming trauma-related emotions and impulses**

Fisher, 2006



Experimenting with Somatic Resources for Traumatic Reactions

Traumatic Reactions:	Resources:
Shaking, trembling	Slowing the pace
Numbing	Sighing, breathing
Muscular hypervigilance	Lengthening the spine
Accelerated heart rate	Hand over the heart
Collapse	Grounding with the feet
Impulses to hurt the body	Clenching/relaxing
Disconnection, spacing out	Movement, gesture

Sensorimotor Psychotherapy Institute Ogden, 2000

Phases of a Brief Therapy Approach

■ **PHASE TWO TASKS (6-10 sessions)**

- **Address the implicit memories triggered by everyday cues:** rather than 'process' event memories, clients need to process the 'living legacy' of implicit body and emotional memories
- **Use mindfulness skills** to change the client's relationship to the past: teach client how to 'uncouple' emotional distress and self-judgment and uncouple images from sensations or movements
- **Build the skills to 'be here now:'** by recognizing implicit memories as 'memories,' identifying intrusive event memories that recur, orienting to present

Fisher, 2018

Treatment modalities that support a brief therapy model

- **EMDR** (Eye Movement Desensitization and Reprocessing): uses event memories as catalyst for implicit images, thoughts, feelings and body sensations that can then be processed nonverbally
- **Sensorimotor Psychotherapy**: a body-oriented talking therapy that uses event memories just to evoke the unprocessed physical and emotional implicit aspects of the trauma
- **Somatic Experiencing**: body-oriented techniques also for processing uncompleted body responses

Treatment modalities that support brief therapy, cont.

- **Brainspotting**: uses visual focusing and bilateral stimulation to process trauma
- **“Flash” EMDR**: provides a good way of regulating the nervous system to process trauma without over-activating implicit memories
- **TRE** (Trauma Releasing Exercises: requires client to have a window of tolerance for success
- **CBT Exposure**: is **not** a good brief therapy approach because of the risk of over-stimulating more fragile, dysregulated clients

Sensorimotor Psychotherapy

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- **Sensorimotor work combines traditional talking therapy techniques with body-centered interventions that directly address the somatic legacy of trauma.**
- Using the narrative only to evoke the trauma-related bodily experience, **we attend first to discovering how the body has “remembered” the trauma and then to providing the somatic experiences needed for resolution**

Sensorimotor Psychotherapy Institute

Years later, do we treat the
memories? or the body responses?

*"While telling 'the story' provides crucial information about the client's past and current life experience, **treatment must address the here-and-now experience of the traumatic past** . . . Thus, 'in the moment' trauma-related emotional reactions, thoughts, images, body sensations and movements that emerge spontaneously in the therapy hour [must] become the focal points of exploration and change."*

Ogden, Minton & Pain (2006)

**"Small gestures and changes in breathing are
at times more significant than the family tree"**

(Christine Caldwell, 1997)

- Sensorimotor Psychotherapy, like EMDR, Brainspotting, SE, and TRE, is ***not focused on what happened then***
- Instead, the narrative is used to evoke the ***nonverbal implicit memories***: the autonomic responses, movements, postural changes, emotions, beliefs, etc.
- ***The therapist looks for patterns***, for habits of response: too much or too little affect, movement or stillness, negative cognitions, patterns of gesture or movement
- ***Therapist and client explore "right here, right now:"*** how is the client organizing internally in response to triggers?
How is the memory being expressed somatically?

Sensorimotor Psychotherapy: Unleashing the Body's Wisdom (2014)

Why work on 'now,' not then?

*"The past is stable. What happened, happened. No matter what we do in therapy . . . , no one can change history. **How it is remembered, how it is reported, how it is felt or interpreted, how we regard it, and different viewpoints [towards it] can all change, but the facts of the past are permanent.** . . . no matter how hard we try or how good our tools. **The good news is, though, we can change the effect the past continues to have on . . . our clients now and in the future.** That is really the aim of trauma recovery . . ."*

Rothschild, 2017

Sensorimotor Principles of Treatment

•**Regulation of arousal is a prerequisite for successful treatment.** When clients are hyper- or hypoaroused, their frontal lobes shut down instinctively, interfering with therapeutic collaboration and integration. Whatever intervention we are using, it must regulate arousal

•**Keeping the frontal lobes ‘online’ must be a priority.** Both mindfulness and psychoeducation facilitate this.

•**Trauma-related conditioned learning must be identified as the “culprit” keeping the trauma ‘alive’** in the client’s body. Whether we identify those to the client or not, they must become the focus of treatment Fisher, 2010

Sensorimotor Principles of Treatment, cont.

•**Observation and disruption of conditioned learning must be done without dysregulating the client!** If we dysregulate the client, there is no new learning

•As we observe the client, we keep in mind at all times that **habitual patterns of response represent creative adaptations to traumatic experiences.** E.g., rather than becoming frustrated with the client who can’t feel anything, we get curious about how that helped him/her to survive.

•**Even self-destructive behavior is viewed as an attempt at a solution, not just as a problem.** Numbing, acting out, self-judgment, shame are all ‘survival resources’ Fisher, 2010

Phases of a Brief Therapy Approach

■ PHASE THREE TASKS (3-6 sessions)

■ **Overcome the phobia of normal life:** increase client tolerance for feeling calm, pleasure, relaxation

■ **Address fears of healthy challenge and change:** increase client tolerance for novelty, healthy risk-taking, visibility, assertiveness

■ **Overcome the phobias of intimacy:** recognizing and re-working hypervigilance, mistrust, habits of avoidance, fight or flight in relationships

■ **Develop a sense of “who I am now after trauma,”** rather than identifying with victimization Fisher, 2018

**“Future Templates:” imagining future
situations in new ways**

- “When you imagine having calm in every cell of your body, what happens? What does that feel like?”
- “Imagine waking up each morning feeling calm in every cell of your body, what happens?”
- If clients feel anxiety or tension, it can be worked with as a traumatic memory. If they feel pleasure or confidence or something positive, help them to ‘stay with’ the new positive feeling
- Ask: “Sense what you would need to feel more confidence [or safety] in that moment?”
- **Build new memories and possibilities**

Fisher, 2018

**Traumatic Attachment = “Enduring
Conditions,” not Events**

“[While] traumatic events are discrete occurrences, . . . disturbed parental affective communications are often an enduring, day-in-day-out feature of the childhood years. Therefore, the resolution of discrete traumatic events in treatment may come about more quickly than the resolution of long-standing patterns of role-reversal, disorientation and disrupted forms of affective communication in the transference.”

Lyons-Ruth et al, 2006, p. 15

**Take advantage of ‘right-brain
to right-brain communication’**

•**Right brain-to right-brain communication is non-verbal.** It is the kind of communication we instinctively use with babies, children, and animals. It relies on the facial muscles, the eyes, larynx, turning movements of the head and neck, as well as on proximity and distance, warmth vs. reserve, touch, and other subtle body communications

•**When we utilize “right brain to right brain” communication,** we pay less attention to the words and more to how we “talk about.” Our actions, tone and body language are used to shift the nonverbal experience of the other instead of our words

Fisher, 2011

Right-brain Communication, cont.

- In trauma work, **the therapist must avoid stimulating either the sense of threat or intense desire for contact** by finding a middle ground between distance or closeness, between warmth and intimacy, support and availability, strength and gentleness, rigidity and flexibility.
- Keep in mind that **“too much” closeness evokes unbearable longing** and triggers fear, fight, or flight, **while “too much” distance is experienced as abandonment**
- Pay more attention to how you are affecting autonomic arousal than to the client’s words or your own in order to maintain an optimal level of arousal in the room

Fisher, 2011

Strategies for neurobiologically regulating clients

- Varying voice tone and pace: soft and slow, hypnotic tone, casual tone, strong and energetic tone, playful tone
- Energy level: very “there” and energetic versus more passive
- Empathy vs. challenge: how does the patient respond to empathy vs. challenge? Does he need confrontation or compassion?
- Amount of information provided: noting the effect of psychoeducation or therapist self-disclosure vs. neutrality
- Titrating vs. encouraging affective expression: “too much” affect or ruminating can be dysregulating
- Speaking in ways that connect client to her resources: intellectual, spiritual, sense of humor, nurturance

Fisher, 2008

“The primary therapeutic attitude [that needs to be] demonstrated [by the therapist] throughout a session is one of :

P = playfulness

A = acceptance

C = curiosity

E = empathy

Hughes, 2006

“Leavening” Distress States with Positive States

“Playful interactions, focused on positive affective experiences, are never forgotten . . . Shame is always met with empathy, followed by curiosity. . . . All communication is ‘embodied’ within the nonverbal. . . . All resistance is met with [playfulness, acceptance, curiosity, and empathy], rather than being confronted.”

Hughes, 2006

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