

13. HEALING FROM TRAUMA: OWNING YOUR SELF

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CHAPTER 13

HEALING FROM TRAUMA: OWNING
YOUR SELF

I don't go to therapy to find out if I'm a freak

I go and I find the one and only answer every week

And when I talk about therapy, I know what people think

That it only makes you selfish and in love with your shrink

But, oh how I loved everybody else

When I finally got to talk so much about myself

—Dar Williams, *What Do You Hear in These Sounds*

obody can “treat” a war, or abuse, rape, molestation, or any other horrendous event, for that matter; what has happened cannot be undone. But what can be dealt with are the imprints of the trauma on body, mind, and soul: the crushing sensations in your chest that you may label as anxiety or depression; the fear of losing control; always being on alert for danger or rejection; the self-loathing; the nightmares and flashbacks; the fog that keeps you from staying on task and from engaging fully in what you are doing; being unable to fully open your heart to another human being.

Trauma robs you of the feeling that you are in charge of yourself, of what I will call self-leadership in the chapters to come.¹ The challenge of recovery is to reestablish ownership of your body and your mind—of your self. This means feeling free to know what you know and to feel what you feel without becoming overwhelmed, enraged, ashamed, or collapsed. For most people this involves (1) finding a way to become calm and focused, (2) learning to maintain that calm in response to images, thoughts, sounds, or physical sensations that remind you of the past, (3) finding a way to be fully alive in the present and engaged with the people around you, (4) not having to keep secrets from yourself, including secrets about the ways that you have managed to survive.

These goals are not steps to be achieved, one by one, in some fixed sequence. They overlap, and some may be more difficult than others, depending on individual circumstances. In each of the chapters that follow, I'll talk about specific methods or approaches to accomplish them. I have tried to make these chapters useful both to trauma survivors and to the therapists who are treating them. People under temporary stress may also find them useful. I've used every one of these methods extensively to treat my patients, and I have also experienced them myself. Some people get

better using just one of these methods, but most are helped by different approaches at different stages of their recovery.

I have done scientific studies of many of the treatments I describe here and have published the research findings in peer-reviewed scientific journals.² My aim in this chapter is to provide an overview of underlying principles, a preview of what's to come, and some brief comments on methods I don't cover in depth later on.

A NEW FOCUS FOR RECOVERY

When we talk about trauma, we often start with a story or a question: “What happened during the war?” “Were you ever molested?” “Let me tell you about that accident or that rape,” or “Was anybody in your family a problem drinker?” However, trauma is much more than a story about something that happened long ago. The emotions and physical sensations that were imprinted during the trauma are experienced not as memories but as disruptive physical reactions in the present.

In order to regain control over your self, you need to revisit the trauma: Sooner or later you need to confront what has happened to you, but only after you feel safe and will not be retraumatized by it. The first order of business is to find ways to cope with feeling overwhelmed by the sensations and emotions associated with the past.

As the previous parts of this book have shown, the engines of posttraumatic reactions are located in the emotional brain. In contrast with the rational brain, which expresses itself in thoughts, the emotional brain manifests itself in physical reactions: gut-wrenching sensations, heart pounding, breathing becoming fast and shallow, feelings of heartbreak, speaking with an uptight and reedy voice, and the characteristic body movements that signify collapse, rigidity, rage, or defensiveness.

Why can't we just be reasonable? And can understanding help? The rational, executive brain is good at helping us understand where feelings come from (as in: “I get scared when I get close to a guy because my father molested me” or “I have trouble expressing my love toward my son because I feel guilty about having killed a child in Iraq”). However, the rational brain cannot abolish emotions, sensations, or thoughts (such as living with a low-level sense of threat or feeling that you are fundamentally a terrible person, even though you rationally know that you are not to blame for having been raped). Understanding why you feel a certain way does not change how you feel. But it can keep you from surrendering to intense reactions (for example, assaulting a boss who reminds you of a perpetrator, breaking up with a lover at your first disagreement, or jumping into the arms of a stranger). However, the more frazzled we are, the more our rational brains take a backseat to our emotions.³

LIMBIC SYSTEM THERAPY

The fundamental issue in resolving traumatic stress is to restore the proper balance between the rational and emotional brains, so that you can feel in charge of how you respond and how you conduct your life. When we're triggered into states of hyper- or hypoarousal, we are pushed outside our “window of tolerance”—the range of optimal functioning.⁴ We become reactive and disorganized; our filters stop working—sounds and lights bother us, unwanted images from the past intrude on our minds, and we panic or fly into rages. If we're shut down, we feel numb in body and mind; our thinking becomes sluggish and we have trouble getting out of our chairs.

As long as people are either hyperaroused or shut down, they cannot

learn from experience. Even if they manage to stay in control, they become so uptight (Alcoholics Anonymous calls this “white-knuckle sobriety”) that they are inflexible, stubborn, and depressed. Recovery from trauma involves the restoration of executive functioning and, with it, self-confidence and the capacity for playfulness and creativity.

If we want to change posttraumatic reactions, we have to access the emotional brain and do “limbic system therapy”: repairing faulty alarm systems and restoring the emotional brain to its ordinary job of being a quiet background presence that takes care of the housekeeping of the body, ensuring that you eat, sleep, connect with intimate partners, protect your children, and defend against danger.

DRAWING BY LICIA SKY

Accessing the emotional brain. The rational, analyzing part of the brain, centered on the dorsolateral prefrontal cortex, has no direct connections with the emotional brain, where most imprints of trauma reside, but the medial prefrontal cortex, the center of self-awareness, does. The neuroscientist Joseph LeDoux and his colleagues have shown that the only way we can consciously access the emotional brain is through self-awareness, i.e. by activating the medial prefrontal cortex, the part of the brain that notices what is going on inside us and thus allows us to feel what we’re feeling.⁵ (The technical term for this is “interoception”—Latin for “looking inside.”) Most of our conscious brain is dedicated to focusing on the outside world: getting along with others and making plans for the future. However, that does not help us manage ourselves. Neuroscience research shows that the only way we can change the way we feel is by becoming aware of our inner experience and learning to befriend what is going inside ourselves.

BEFRIENDING THE EMOTIONAL BRAIN

1. DEALING WITH HYPERAROUSAL

Over the past few decades mainstream psychiatry has focused on using drugs to change the way we feel, and this has become the accepted way to deal with hyper- and hypoarousal. I will discuss drugs later in this chapter, but first I need to stress the fact that we have a host of inbuilt skills to keep us on an even keel. In chapter 5 we saw how emotions are registered in the body. Some 80 percent of the fibers of the vagus nerve (which connects the brain with many internal organs) are afferent; that is, they run from the body into the brain.⁶ This means that we can directly train our arousal system by the way we breathe, chant, and move, a principle that has been utilized since time immemorial in places like China and India, and in every religious practice that I know of, but that is suspiciously eyed as “alternative” in mainstream culture.

In research supported by the National Institutes of Health, my colleagues and I have shown that ten weeks of yoga practice markedly reduced the PTSD symptoms of patients who had failed to respond to any medication or to any other treatment.⁷ (I will discuss yoga in chapter 16.) Neurofeedback, the topic of chapter 19, also can be particularly effective for children and adults who are so hyperaroused or shut down that they have trouble focusing and prioritizing.⁸

Learning how to breathe calmly and remaining in a state of relative physical relaxation, even while accessing painful and horrifying memories, is an essential tool for recovery.⁹ When you deliberately take a few slow, deep breaths, you will notice the effects of the parasympathetic brake on your arousal (as explained in chapter 5). The more you stay focused on your breathing, the more you will benefit, particularly if you pay attention until

the very end of the out breath and then wait a moment before you inhale again. As you continue to breathe and notice the air moving in and out of your lungs you may think about the role that oxygen plays in nourishing your body and bathing your tissues with the energy you need to feel alive and engaged. Chapter 16 documents the full-body effects of this simple practice.

Since emotional regulation is the critical issue in managing the effects of trauma and neglect, it would make an enormous difference if teachers, army sergeants, foster parents, and mental health professionals were thoroughly schooled in emotional-regulation techniques. Right now this still is mainly the domain of preschool and kindergarten teachers, who deal with immature brains and impulsive behavior on a daily basis and who are often very adept at managing them.¹⁰

Mainstream Western psychiatric and psychological healing traditions have paid scant attention to self-management. In contrast to the Western reliance on drugs and verbal therapies, other traditions from around the world rely on mindfulness, movement, rhythms, and action. Yoga in India, tai chi and qigong in China, and rhythmical drumming throughout Africa are just a few examples. The cultures of Japan and the Korean peninsula have spawned martial arts, which focus on the cultivation of purposeful movement and being centered in the present, abilities that are damaged in traumatized individuals. Aikido, judo, tae kwon do, kendo, and jujitsu, as well as capoeira from Brazil, are examples. These techniques all involve physical movement, breathing, and meditation. Aside from yoga, few of these popular non-Western healing traditions have been systematically studied for the treatment of PTSD.

2. NO MIND WITHOUT MINDFULNESS

At the core of recovery is self-awareness. The most important phrases in trauma therapy are “Notice that” and “What happens next?” Traumatized people live with seemingly unbearable sensations: They feel heartbroken and suffer from intolerable sensations in the pit of their stomach or tightness in their chest. Yet avoiding feeling these sensations in our bodies increases our vulnerability to being overwhelmed by them.

Body awareness puts us in touch with our inner world, the landscape of our organism. Simply noticing our annoyance, nervousness, or anxiety immediately helps us shift our perspective and opens up new options other than our automatic, habitual reactions. Mindfulness puts us in touch with the transitory nature of our feelings and perceptions. When we pay focused attention to our bodily sensations, we can recognize the ebb and flow of our emotions and, with that, increase our control over them.

Traumatized people are often afraid of feeling. It is not so much the perpetrators (who, hopefully, are no longer around to hurt them) but their own physical sensations that now are the enemy. Apprehension about being hijacked by uncomfortable sensations keeps the body frozen and the mind shut. Even though the trauma is a thing of the past, the emotional brain keeps generating sensations that make the sufferer feel scared and helpless. It's not surprising that so many trauma survivors are compulsive eaters and drinkers, fear making love, and avoid many social activities: Their sensory world is largely off limits.

In order to change you need to open yourself to your inner experience. The first step is to allow your mind to focus on your sensations and notice how, in contrast to the timeless, ever-present experience of trauma, physical sensations are transient and respond to slight shifts in body position,

changes in breathing, and shifts in thinking. Once you pay attention to your physical sensations, the next step is to label them, as in “When I feel anxious, I feel a crushing sensation in my chest.” I may then say to a patient: “Focus on that sensation and see how it changes when you take a deep breath out, or when you tap your chest just below your collarbone, or when you allow yourself to cry.” Practicing mindfulness calms down the sympathetic nervous system, so that you are less likely to be thrown into fight-or-flight.¹¹ Learning to observe and tolerate your physical reactions is a prerequisite for safely revisiting the past. If you cannot tolerate what you are feeling right now, opening up the past will only compound the misery and retraumatize you further.¹²

We can tolerate a great deal of discomfort as long as we stay conscious of the fact that the body’s commotions constantly shift. One moment your chest tightens, but after you take a deep breath and exhale, that feeling softens and you may observe something else, perhaps a tension in your shoulder. Now you can start exploring what happens when you take a deeper breath and notice how your rib cage expands.¹³ Once you feel calmer and more curious, you can go back to that sensation in your shoulder. You should not be surprised if a memory spontaneously arises in which that shoulder was somehow involved.

A further step is to observe the interplay between your thoughts and your physical sensations. How are particular thoughts registered in your body? (Do thoughts like “My father loves me” or “my girlfriend dumped me” produce different sensations?) Becoming aware of how your body organizes particular emotions or memories opens up the possibility of releasing sensations and impulses you once blocked in order to survive.¹⁴ In chapter 20, on the benefits of theater, I’ll describe in more detail how this works.

Jon Kabat-Zinn, one of the pioneers in mind-body medicine, founded the Mindfulness-Based Stress Reduction (MBSR) program at the University of Massachusetts Medical Center in 1979, and his method has been thoroughly studied for more than three decades. As he describes mindfulness, “One way to think of this process of transformation is to think of mindfulness as a lens, taking the scattered and reactive energies of your mind and focusing them into a coherent source of energy for living, for problem solving, for healing.”¹⁵

Mindfulness has been shown to have a positive effect on numerous psychiatric, psychosomatic, and stress-related symptoms, including depression and chronic pain.¹⁶ It has broad effects on physical health, including improvements in immune response, blood pressure, and cortisol levels.¹⁷ It has also been shown to activate the brain regions involved in emotional regulation¹⁸ and to lead to changes in the regions related to body awareness and fear.¹⁹ Research by my Harvard colleagues Britta Hölzel and Sara Lazar has shown that practicing mindfulness even decreases the activity of the brain’s smoke detector, the amygdala, and thus decreases reactivity to potential triggers.²⁰

3. RELATIONSHIPS

Study after study shows that having a good support network constitutes the single most powerful protection against becoming traumatized. Safety and terror are incompatible. When we are terrified, nothing calms us down like the reassuring voice or the firm embrace of someone we trust. Frightened adults respond to the same comforts as terrified children: gentle holding and rocking and the assurance that somebody bigger and stronger is taking care

of things, so you can safely go to sleep. In order to recover, mind, body, and brain need to be convinced that it is safe to let go. That happens only when you feel safe at a visceral level and allow yourself to connect that sense of safety with memories of past helplessness.

After an acute trauma, like an assault, accident, or natural disaster, survivors require the presence of familiar people, faces, and voices; physical contact; food; shelter and a safe place; and time to sleep. It is critical to communicate with loved ones close and far and to reunite as soon as possible with family and friends in a place that feels safe. Our attachment bonds are our greatest protection against threat. For example, children who are separated from their parents after a traumatic event are likely to suffer serious negative long-term effects. Studies conducted during World War II in England showed that children who lived in London during the Blitz and were sent away to the countryside for protection against German bombing raids fared much worse than children who remained with their parents and endured nights in bomb shelters and frightening images of destroyed buildings and dead people.²¹

Traumatized human beings recover in the context of relationships: with families, loved ones, AA meetings, veterans' organizations, religious communities, or professional therapists. The role of those relationships is to provide physical and emotional safety, including safety from feeling shamed, admonished, or judged, and to bolster the courage to tolerate, face, and process the reality of what has happened.

As we have seen, much the wiring of our brain circuits is devoted to being in tune with others. Recovery from trauma involves (re)connecting with our fellow human beings. This is why trauma that has occurred within relationships is generally more difficult to treat than trauma resulting from traffic accidents or natural disasters. In our society the most common traumas in women and children occur at the hands of their parents or intimate partners. Child abuse, molestation, and domestic violence all are inflicted by people who are supposed to love you. That knocks out the most important protection against being traumatized: being sheltered by the people you love.

If the people whom you naturally turn to for care and protection terrify or reject you, you learn to shut down and to ignore what you feel.²² As we saw in part 3, when your caregivers turn on you, you have to find alternative ways to deal with feeling scared, angry, or frustrated. Managing your terror all by yourself gives rise to another set of problems: dissociation, despair, addictions, a chronic sense of panic, and relationships that are marked by alienation, disconnection, and explosions. Patients with these histories rarely make the connection between what happened to them long ago and how they currently feel and behave. Everything just seems unmanageable.

Relief does not come until they are able to acknowledge what has happened and recognize the invisible demons they're struggling with. Recall, for example, the men I described in chapter 11 who had been abused by pedophile priests. They visited the gym regularly, took anabolic steroids, and were strong as oxen. However, in our interviews they often acted like scared kids; the hurt boys deep inside still felt helpless.

While human contact and attunement are the wellspring of physiological self-regulation, the promise of closeness often evokes fear of getting hurt, betrayed, and abandoned. Shame plays an important role in this: "You will find out how rotten and disgusting I am and dump me as

soon as you really get to know me.” Unresolved trauma can take a terrible toll on relationships. If your heart is still broken because you were assaulted by someone you loved, you are likely to be preoccupied with not getting hurt again and fear opening up to someone new. In fact, you may unwittingly try to hurt them before they have a chance to hurt you. This poses a real challenge for recovery. Once you recognize that posttraumatic reactions started off as efforts to save your life, you may gather the courage to face your inner music (or cacophony), but you will need help to do so. You have to find someone you can trust enough to accompany you, someone who can safely hold your feelings and help you listen to the painful messages from your emotional brain. You need a guide who is not afraid of your terror and who can contain your darkest rage, someone who can safeguard the wholeness of you while you explore the fragmented experiences that you had to keep secret from yourself for so long. Most traumatized individuals need an anchor and a great deal of coaching to do this work.

Choosing a Professional Therapist

The training of competent trauma therapists involves learning about the impact of trauma, abuse, and neglect and mastering a variety of techniques that can help to (1) stabilize and calm patients down, (2) help to lay traumatic memories and reenactments to rest, and (3) reconnect patients with their fellow men and women. Ideally the therapist will also have been on the receiving end of whatever therapy he or she practices.

While it's inappropriate and unethical for therapists to tell you the details of their personal struggles, it is perfectly reasonable to ask what particular forms of therapy they have been trained in, where they learned their skills, and whether they've personally benefited from the therapy they propose for you.

There is no one “treatment of choice” for trauma, and any therapist who believes that his or her particular method is the only answer to your problems is suspect of being an ideologue rather than somebody who is interested in making sure that you get well. No therapist can possibly be familiar with every effective treatment, and he or she must be open to your exploring options other than the ones he or she offers. He or she also must be open to learning from you. Gender, race, and personal background are relevant only if they interfere with helping the patient feel safe and understood.

Do you feel basically comfortable with this therapist? Does he or she seem to feel comfortable in his or her own skin and with you as a fellow human being? Feeling safe is a necessary condition for you to confront your fears and anxieties. Someone who is stern, judgmental, agitated, or harsh is likely to leave you feeling scared, abandoned, and humiliated, and that won't help you resolve your traumatic stress. There may be times as old feelings from the past are stirred up, when you become suspicious that the therapist resembles someone who once hurt or abused you. Hopefully, this is something you can work through together, because in my experience patients get better only if they develop deep positive feelings for their therapists. I also don't think that you can grow and change unless you feel that you have some impact on the person who is treating you.

The critical question is this: Do you feel that your therapist is curious to find out who you are and what you, not some generic “PTSD patient,” need? Are you just a list of symptoms on some diagnostic questionnaire, or does your therapist take the time to find out why you do what you do and

think what you think? Therapy is a collaborative process—a mutual exploration of your self.

Patients who have been brutalized by their caregivers as children often do not feel safe with anyone. I often ask my patients if they can think of any person they felt safe with while they were growing up. Many of them hold tight to the memory of that one teacher, neighbor, shopkeeper, coach, or minister who showed that he or she cared, and that memory is often the seed of learning to reengage. We are a hopeful species. Working with trauma is as much about remembering how we survived as it is about what is broken.

I also ask my patients to imagine what they were like as newborns—whether they were lovable and filled with spunk. All of them believe they were and have some image of what they must have been like before they were hurt.

Some people don't remember anybody they felt safe with. For them, engaging with horses or dogs may be much safer than dealing with human beings. This principle is currently being applied in many therapeutic settings to great effect, including in jails, residential treatment programs, and veterans' rehabilitation. Jennifer, a member of the first graduating class of the Van der Kolk Center,²³ who had come to the program as an out-of-control, mute fourteen-year-old, said during her graduation ceremony that having been entrusted with the responsibility of caring for a horse was the critical first step for her. Her growing bond with her horse helped her feel safe enough to begin to relate to the staff of the center and then to focus on her classes, take her SATs, and be accepted to college.²⁴

4. COMMUNAL RHYTHMS AND SYNCHRONY

From the moment of our birth, our relationships are embodied in responsive faces, gestures, and touch. As we saw in chapter 7, these are the foundations of attachment. Trauma results in a breakdown of attuned physical synchrony: When you enter the waiting room of a PTSD clinic, you can immediately tell the patients from the staff by their frozen faces and collapsed (but simultaneously agitated) bodies. Unfortunately, many therapists ignore those physical communications and focus only on the words with which their patients communicate.

The healing power of community as expressed in music and rhythms was brought home for me in the spring of 1997, when I was following the work of the Truth and Reconciliation Commission in South Africa. In some places we visited, terrible violence continued. One day I attended a group for rape survivors in the courtyard of a clinic in a township outside Johannesburg. We could hear the sound of bullets being fired at a distance while smoke billowed over the walls of the compound and the smell of teargas hung in the air. Later we heard that forty people had been killed. Yet, while the surroundings were foreign and terrifying, I recognized this group all too well: The women sat slumped over—sad and frozen—like so many rape therapy groups I had seen in Boston. I felt a familiar sense of helplessness, and, surrounded by collapsed people, I felt myself mentally collapse as well. Then one of the women started to hum, while gently swaying back and forth. Slowly a rhythm emerged; bit by bit other women joined in. Soon the whole group was singing, moving, and getting up to dance. It was an astounding transformation: people coming back to life, faces becoming attuned, vitality returning to bodies. I made a vow to apply what I was seeing there and to study how rhythm, chanting, and movement can help to heal trauma.

We will see more of this in chapter 20, on theater, where I show how groups of young people—among them juvenile offenders and at-risk foster kids—gradually learn to work together and to depend on one another, whether as partners in Shakespearean swordplay or as the writers and performers of full-length musicals. Different patients have told me how much choral singing, aikido, tango dancing, and kickboxing have helped them, and I am delighted to pass their recommendations on to other people I treat.

I learned another powerful lesson about rhythm and healing when clinicians at the Trauma Center were asked to treat a five-year-old mute girl, Ying Mee, who had been adopted from an orphanage in China. After months of failed attempts to make contact with her, my colleagues Deborah Rozelle and Liz Warner realized that her rhythmical engagement system didn't work—she could not resonate with the voices and faces of the people around her. That led them to sensorimotor therapy.²⁵

The sensory integration clinic in Watertown, Massachusetts, is a wondrous indoor playground filled with swings, tubs full of multicolored rubber balls so deep that you can make yourself disappear, balance beams, crawl spaces fashioned from plastic tubing, and ladders that lead to platforms from which you can dive onto foam-filled mats. The staff bathed Ying Mee in the tub with plastic balls; that helped her feel sensations on her skin. They helped her sway on swings and crawl under weighted blankets. After six weeks something shifted—and she started to talk.²⁶

Ying Mee's dramatic improvement inspired us to start a sensory integration clinic at the Trauma Center, which we now also use in our residential treatment programs. We have not yet explored how well sensory integration works for traumatized adults, but I regularly incorporate sensory integration experiences and dance in my seminars.

Learning to become attuned provides parents (and their kids) with the visceral experience of reciprocity. Parent-child interaction therapy (PCIT) is an interactive therapy that fosters this, as is SMART (sensory motor arousal regulation treatment), developed by my colleagues at the Trauma Center.²⁷ When we play together, we feel physically attuned and experience a sense of connection and joy. Improvisation exercises (such as those found at <http://learnimprov.com/>) also are a marvelous way to help people connect in joy and exploration. The moment you see a group of grim-faced people break out in a giggle, you know that the spell of misery has broken.

5. GETTING IN TOUCH

Mainstream trauma treatment has paid scant attention to helping terrified people to safely experience their sensations and emotions. Medications such as serotonin reuptake blockers, Resperidol and Seroquel increasingly have taken the place of helping people to deal with their sensory world.²⁸

However, the most natural way that we humans calm down our distress is by being touched, hugged, and rocked. This helps with excessive arousal and makes us feel intact, safe, protected, and in charge.

Rembrandt van Rijn: Christ Healing the Sick. Gestures of comfort are universally recognizable and reflect the healing power of attuned touch.

Touch, the most elementary tool that we have to calm down, is proscribed from most therapeutic practices. Yet you can't fully recover if you don't feel safe in your skin. Therefore, I encourage all my patients to engage in some sort of bodywork, be it therapeutic massage, Feldenkrais, or craniosacral therapy.

I asked my favorite bodywork practitioner, Licia Sky, about her

practice with traumatized individuals. Here is some of what she told me: “I never begin a bodywork session without establishing a personal connection. I’m not taking a history; I’m not finding out how traumatized a person is or what happened to them. I check in where they are in their body right now. I ask them if there is anything they want me to pay attention to. All the while, I’m assessing their posture; whether they look me in the eye; how tense or relaxed they seem; are they connecting with me or not.

“The first decision I make is if they will feel safer face up or face down. If I don’t know them, I usually start face up. I am very careful about draping; very careful to let them feel safe with whatever clothing they want to leave on. These are important boundaries to set up right at the beginning.

“Then, with my first touch, I make firm, safe contact. Nothing forced or sharp. Nothing too fast. The touch is slow, easy for the client to follow, gently rhythmic. It can be as strong as a handshake. The first place I might touch is their hand and forearm, because that’s the safest place to touch anybody, the place where they can touch you back.

“You have to meet their point of resistance—the place that has the most tension—and meet it with an equal amount of energy. That releases the frozen tension. You can’t hesitate; hesitation communicates a lack of trust in yourself. Slow movement, careful attuning to the client is different from hesitation. You have to meet them with tremendous confidence and empathy, let the pressure of your touch meet the tension they are holding in their bodies.”

What does bodywork do for people? Licia’s reply: “Just like you can thirst for water, you can thirst for touch. It is a comfort to be met confidently, deeply, firmly, gently, responsively. Mindful touch and movement grounds people and allows them to discover tensions that they may have held for so long that they are no longer even aware of them. When you are touched, you wake up to the part of your body that is being touched.

“The body is physically restricted when emotions are bound up inside. People’s shoulders tighten; their facial muscles tense. They spend enormous energy on holding back their tears—or any sound or movement that might betray their inner state. When the physical tension is released, the feelings can be released. Movement helps breathing to become deeper, and as the tensions are released, expressive sounds can be discharged. The body becomes freer—breathing freer, being in flow. Touch makes it possible to live in a body that can move in response to being moved.

“People who are terrified need to get a sense of where their bodies are in space and of their boundaries. Firm and reassuring touch lets them know where those boundaries are: what’s outside them, where their bodies end. They discover that they don’t constantly have to wonder who and where they are. They discover that their body is solid and that they don’t have to be constantly on guard. Touch lets them know that they are safe.”

6. TAKING ACTION

The body responds to extreme experiences by secreting stress hormones. These are often blamed for subsequent illness and disease. However, stress hormones are meant to give us the strength and endurance to respond to extraordinary conditions. People who actively do something to deal with a disaster—rescuing loved ones or strangers, transporting people to a hospital, being part of a medical team, pitching tents or cooking meals—utilize their stress hormones for their proper purpose and therefore are at much lower risk of becoming traumatized. (Nonetheless, everyone has his

or her breaking point, and even the best-prepared person may become overwhelmed by the magnitude of the challenge.)

Helplessness and immobilization keep people from utilizing their stress hormones to defend themselves. When that happens, their hormones still are being pumped out, but the actions they're supposed to fuel are thwarted. Eventually, the activation patterns that were meant to promote coping are turned back against the organism and now keep fueling inappropriate fight/flight and freeze responses. In order to return to proper functioning, this persistent emergency response must come to an end. The body needs to be restored to a baseline state of safety and relaxation from which it can mobilize to take action in response to real danger.

My friends and teachers Pat Ogden and Peter Levine have each developed powerful body-based therapies, sensorimotor psychotherapy²⁹ and somatic experiencing³⁰ to deal with this issue. In these treatment approaches the story of what has happened takes a backseat to exploring physical sensations and discovering the location and shape of the imprints of past trauma on the body. Before plunging into a full-fledged exploration of the trauma itself, patients are helped to build up internal resources that foster safe access sensations and emotions that overwhelmed them at the time of the trauma. Peter Levine calls this process pendulation—gently moving in and out of accessing internal sensations and traumatic memories. In this way patients are helped to gradually expand their window of tolerance.

Once patients can tolerate being aware of their trauma-based physical experiences, they are likely to discover powerful physical impulses—like hitting, pushing, or running—that arose during the trauma but were suppressed in order to survive. These impulses manifest themselves in subtle body movements such as twisting, turning, or backing away. Amplifying these movements and experimenting with ways to modify them begins the process of bringing the incomplete, trauma-related “action tendencies” to completion and can eventually lead to resolution of the trauma. Somatic therapies can help patients to relocate themselves in the present by experiencing that it is safe to move. Feeling the pleasure of taking effective action restores a sense of agency and a sense of being able to actively defend and protect themselves.

Back in 1893 Pierre Janet, the first great explorer of trauma, wrote about “the pleasure of completed action,” and I regularly observe that pleasure when I practice sensorimotor psychotherapy and somatic experiencing: When patients can physically experience what it would have felt like to fight back or run away, they relax, smile, and express a sense of completion.

When people are forced to submit to overwhelming power, as is true for most abused children, women trapped in domestic violence, and incarcerated men and women, they often survive with resigned compliance. The best way to overcome ingrained patterns of submission is to restore a physical capacity to engage and defend. One of my favorite body-oriented ways to build effective fight/flight responses is our local impact center's model mugging program, in which women (and increasingly men) are taught to actively fight off a simulated attack.³¹ The program started in Oakland, California, in 1971 after a woman with a fifth-degree black belt in karate was raped. Wondering how this could have happened to someone who supposedly could kill with her bare hands, her friends concluded that she had become de-skilled by fear. In the terms of this book, her executive

functions—her frontal lobes—went off-line, and she froze. The model mugging program teaches women to recondition the freeze response through many repetitions of being placed in the “zero hour” (a military term for the precise moment of an attack) and learning to transform fear into positive fighting energy.

One of my patients, a college student with a history of unrelenting child abuse, took the course. When I first met her, she was collapsed, depressed, and overly compliant. Three months later, during her graduation ceremony, she successfully fought off a gigantic male attacker who ended up lying cringing on the floor (shielded from her blows by a thick protective suit) while she faced him, arms raised in a karate stance, calmly and clearly yelling no.

Not long afterward, she was walking home from the library after midnight when three men jumped out of some bushes, yelling: “Bitch, give us your money.” She later told me that she took that same karate stance and yelled back: “Okay, guys, I’ve been looking forward to this moment. Who wants to take me on first?” They ran away. If you’re hunched over and too afraid to look around, you are easy prey to other people’s sadism, but when you walk around projecting the message “Don’t mess with me,” you’re not likely to be bothered.

INTEGRATING TRAUMATIC MEMORIES

People cannot put traumatic events behind until they are able to acknowledge what has happened and start to recognize the invisible demons they’re struggling with. Traditional psychotherapy has focused mainly on constructing a narrative that explains why a person feels a particular way or, as Sigmund Freud put it back in 1914 in *Remembering, Repeating and Working Through*:³² “While the patient lives [the trauma] through as something real and actual, we have to accomplish the therapeutic task, which consists chiefly of translating it back again in terms of the past.” Telling the story is important; without stories, memory becomes frozen; and without memory you cannot imagine how things can be different. But as we saw in part 4, telling a story about the event does not guarantee that the traumatic memories will be laid to rest.

There is a reason for that. When people remember an ordinary event, they do not also relive the physical sensations, emotions, images, smells, or sounds associated with that event. In contrast, when people fully recall their traumas, they “have” the experience: They are engulfed by the sensory or emotional elements of the past. The brain scans of Stan and Ute Lawrence, the accident victims in chapter 4, show how this happens. When Stan was remembering his horrendous accident, two key areas in his brain went blank: the area that provides a sense of time and perspective, which makes it possible to know that “that was then, but I am safe now,” and another area that integrates the images, sounds, and sensations of trauma into a coherent story. When those parts of the brain are knocked out, you experience something not as an event with a beginning, a middle, and an end but in fragments of sensations, images, and emotions.

A trauma can be successfully processed only if all those brain structures are kept online. In Stan’s case, eye movement desensitization and reprocessing (EMDR) allowed him to access his memories of the accident without being overwhelmed by them. When the brain areas whose absence is responsible for flashbacks can be kept online while remembering what has happened, people can integrate their traumatic memories as belonging to the past.

Ute's dissociation (as you recall, she shut down completely) complicated recovery in a different way. None of the brain structures necessary to engage in the present were online, so that dealing with the trauma was simply impossible. Without a brain that is alert and present there can be no integration and resolution. She needed to be helped to increase her window of tolerance before she could deal with her PTSD symptoms.

Hypnosis was the most widely practiced treatment for trauma from the late 1800s, the time of Pierre Janet and Sigmund Freud, until after World War II. On YouTube you can still watch the documentary *Let There Be Light*, by the great Hollywood director John Huston, which shows men undergoing hypnosis to treat "war neurosis." Hypnosis fell out of favor in the early 1990s and there have been no recent studies of its effectiveness for treating PTSD. However, hypnosis can induce a state of relative calm from which patients can observe their traumatic experiences without being overwhelmed by them. Since that capacity to quietly observe oneself is a critical factor in the integration of traumatic memories, it is likely that hypnosis, in some form, will make a comeback.

COGNITIVE BEHAVIORAL THERAPY (CBT)

During their training most psychologists are taught cognitive behavioral therapy. CBT was first developed to treat phobias such as fear of spiders, airplanes, or heights, to help patients compare their irrational fears with harmless realities. Patients are gradually desensitized from their irrational fears by bringing to mind what they are most afraid of, using their narratives and images ("imaginal exposure"), or they are placed in actual (but actually safe) anxiety-provoking situations ("in vivo exposure"), or they are exposed to virtual-reality, computer-simulated scenes, for example, in the case of combat-related PTSD, fighting in the streets of Fallujah. The idea behind cognitive behavioral treatment is that when patients are repeatedly exposed to the stimulus without bad things actually happening, they gradually will become less upset; the bad memories will have become associated with "corrective" information of being safe.³³ CBT also tries to help patients deal with their tendency to avoid, as in "I don't want to talk about it."³⁴ It sounds simple, but, as we have seen, reliving trauma reactivates the brain's alarm system and knocks out critical brain areas necessary for integrating the past, making it likely that patients will relive rather than resolve the trauma.

Prolonged exposure or "flooding" has been studied more thoroughly than any other PTSD treatment. Patients are asked to "focus their attention on the traumatic material and . . . not distract themselves with other thoughts or activities."³⁵ Research has shown that up to one hundred minutes of flooding (in which anxiety-provoking triggers are presented in an intense, sustained form) are required before decreases in anxiety are reported.³⁶ Exposure sometimes helps to deal with fear and anxiety, but it has not been proven to help with guilt or other complex emotions.³⁷ In contrast to its effectiveness for irrational fears such as spiders, CBT has not done so well for traumatized individuals, particularly those with histories of childhood abuse. Only about one in three participants with PTSD who finish research studies show some improvement.³⁸ Those who complete CBT treatment usually have fewer PTSD symptoms, but they rarely recover completely: Most continue to have substantial problems with their health, work, or mental well-being.³⁹

In the largest published study of CBT for PTSD more than one-third of

the patients dropped out; the rest had a significant number of adverse reactions. Most of the women in the study still suffered from full-blown PTSD after three months in the study, and only 15 percent no longer had major PTSD symptoms.⁴⁰ A thorough analysis of all the scientific studies of CBT show that it works about as well as being in a supportive therapy relationship.⁴¹ The poorest outcome in exposure treatments occurs in patients who suffer from “mental defeat”—those who have given up.⁴² Being traumatized is not just an issue of being stuck in the past; it is just as much a problem of not being fully alive in the present. One form of exposure treatment is virtual-reality therapy in which veterans wear high-tech goggles that make it possible to refight the battle of Fallujah in lifelike detail. As far as I know, the US Marines performed very well in combat. The problem is that they cannot tolerate being home. Recent studies of Australian combat veterans show that their brains are rewired to be alert for emergencies, at the expense of being focused on the small details of everyday life.⁴³ (We’ll learn more about this in chapter 19, on neurofeedback.) More than virtual-reality therapy, traumatized patients need “real world” therapy, which helps them to feel as alive when walking through the local supermarket or playing with their kids as they did in the streets of Baghdad.

Patients can benefit from reliving their trauma only if they are not overwhelmed by it. A good example is a study of Vietnam veterans conducted in the early 1990s by my colleague Roger Pitman.⁴⁴ I visited Roger’s lab every week during that time, since we were conducting the study of brain opioids in PTSD that I discussed in chapter 2. Roger would show me the videotapes of his treatment sessions and we would discuss what we observed. He and his colleagues pushed the veterans to talk repeatedly about every detail of their experiences in Vietnam, but the investigators had to stop the study because many patients became panicked by their flashbacks, and the dread often persisted after the sessions. Some never returned, while many of those who stayed with the study became more depressed, violent, and fearful; some coped with their increased symptoms by increasing their alcohol consumption, which led to further violence and humiliation, as some of their families called the police to take them to a hospital.

DESENSITIZATION

Over the past two decades the prevailing treatment taught to psychology students has been some form of systematic desensitization: helping patients become less reactive to certain emotions and sensations. But is this the correct goal? Maybe the issue is not desensitization but integration: putting the traumatic event into its proper place in the overall arc of one’s life. Desensitization makes me think of the small boy—he must have been about five—I saw in front of my house recently. His hulking father was yelling at him at the top of his voice as the boy rode his tricycle down my street. The kid was unfazed, while my heart was racing and I felt an impulse to deck the guy. How much brutality had it taken to numb a child this young to his father’s brutality? His indifference to his father’s yelling must have been the result of prolonged exposure, but, I wondered, at what price? Yes, we can take drugs that blunt our emotions or we can learn to desensitize ourselves. As medical students we learned to stay analytical when we had to treat children with third-degree burns. But, as the neuroscientist Jean Decety at the University of Chicago has shown, desensitization to our own or to other people’s pain tends to lead to an overall blunting of emotional

sensitivity.⁴⁵

A 2010 report on 49,425 veterans with newly diagnosed PTSD from the Iraq and Afghanistan wars who sought care from the VA showed that fewer than one out of ten actually completed the recommended treatment.⁴⁶ As in Pitman's Vietnam veterans, exposure treatment, as currently practiced, rarely works for them. We can only "process" horrendous experiences if they do not overwhelm us. And that means that other approaches are necessary.

DRUGS TO SAFELY ACCESS TRAUMA?

When I was a medical student, I spent the summer of 1966 working for Jan Bastiaans, a professor at Leiden University in the Netherlands who was known for his work treating Holocaust survivors with LSD. He claimed to have achieved spectacular results, but when colleagues inspected his archives, they found few data to support his claims. The potential of mind-altering substances for trauma treatment was subsequently neglected until 2000, when Michael Mithoefer and his colleagues in South Carolina received FDA permission to conduct an experiment with MDMA (ecstasy). MDMA was classified as a controlled substance in 1985 after having been used for years as a recreational drug. As with Prozac and other psychotropic agents, we don't know exactly how MDMA works, but it is known to increase concentrations of a number of important hormones including oxytocin, vasopressin, cortisol, and prolactin.⁴⁷ Most relevant for trauma treatment, it increases people's awareness of themselves; they frequently report a heightened sense of compassionate energy, accompanied by curiosity, clarity, confidence, creativity, and connectedness. Mithoefer and his colleagues were looking for a medication that would enhance the effectiveness of psychotherapy, and they became interested in MDMA because it decreases fear, defensiveness, and numbing, as well as helping to access inner experience.⁴⁸ They thought MDMA might enable patients to stay within the window of tolerance so they could revisit their traumatic memories without suffering overwhelming physiological and emotional arousal.

The initial pilot studies have supported that expectation.⁴⁹ The first study, involving combat veterans, firefighters, and police officers with PTSD, had positive results. In the next study, of a group of twenty victims of assault who had been unresponsive to previous forms of therapy, twelve subjects received MDMA and eight received an inactive placebo. Sitting or lying in a comfortable room, they then all received two eight-hour psychotherapy sessions, mainly using internal family systems (IFS) therapy, the subject of chapter 17 of this book. Two months later 83 percent of the patients who received MDMA plus psychotherapy were considered completely cured, compared with 25 percent of the placebo group. None of the patients had adverse side effects. Perhaps most interesting, when the participants were interviewed more than a year after the study was completed, they had maintained their gains.

By being able to observe the trauma from the calm, mindful state that IFS calls Self (a term I'll discuss further in chapter 17), mind and brain are in a position to integrate the trauma into the overall fabric of life. This is very different from traditional desensitization techniques, which are about blunting a person's response to past horrors. This is about association and integration—making a horrendous event that overwhelmed you in the past into a memory of something that happened a long time ago.

Nonetheless, psychedelics are powerful agents with a

troubled history. They can easily be misused through careless administration and poor maintenance of therapeutic boundaries. It is to be hoped that MDMA will not be another magic cure released from Pandora's box.

WHAT ABOUT MEDICATIONS?

People have always used drugs to deal with traumatic stress. Each culture and each generation has its preferences—gin, vodka, beer, or whiskey; hashish, marijuana, cannabis, or ganja; cocaine; opioids like oxycontin; tranquilizers such as Valium, Xanax, and Klonopin. When people are desperate, they will do just about anything to feel calmer and more in control.⁵⁰

Mainstream psychiatry follows this tradition. Over the past decade the Departments of Defense and Veterans Affairs combined have spent over \$4.5 billion on antidepressants, antipsychotics, and anti-anxiety drugs. A June 2010 internal report from the Defense Department's Pharmacoeconomic Center at Fort Sam Houston in San Antonio showed that 213,972, or 20 percent of the 1.1 million active-duty troops surveyed, were taking some form of psychotropic drug: antidepressants, antipsychotics, sedative hypnotics, or other controlled substances.⁵¹

However, drugs cannot "cure" trauma; they can only dampen the expressions of a disturbed physiology. And they do not teach the lasting lessons of self-regulation. They can help to control feelings and behavior, but always at a price—because they work by blocking the chemical systems that regulate engagement, motivation, pain, and pleasure. Some of my colleagues remain optimistic: I keep attending meetings where serious scientists discuss their quest for the elusive magic bullet that will miraculously reset the fear circuits of the brain (as if traumatic stress involved only one simple brain circuit). I also regularly prescribe medications.

Just about every group of psychotropic agents has been used to treat some aspect of PTSD.⁵² The serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, Effexor, and Paxil have been most thoroughly studied, and they can make feelings less intense and life more manageable. Patients on SSRIs often feel calmer and more in control; feeling less overwhelmed often makes it easier to engage in therapy. Other patients feel blunted by SSRIs—they feel they're "losing their edge." I approach it as an empirical question: Let's see what works, and only the patient can be the judge of that. On the other hand, if one SSRI does not work, it's worth trying another, because they all have slightly different effects. It's interesting that the SSRIs are widely used to treat depression, but in a study in which we compared Prozac with eye movement desensitization and reprocessing (EMDR) for patients with PTSD, many of whom were also depressed, EMDR proved to be a more effective antidepressant than Prozac.⁵³ I'll return to that subject in chapter 15.⁵⁴

Medicines that target the autonomic nervous system, like propranolol or clonidine, can help to decrease hyperarousal and reactivity to stress.⁵⁵ This family of drugs works by blocking the physical effects of adrenaline, the fuel of arousal, and thus reduces nightmares, insomnia, and reactivity to trauma triggers.⁵⁶ Blocking adrenaline can help to keep the rational brain online and make choices possible: "Is this really what I want to do?" Since I have started to integrate mindfulness and yoga into my practice, I use these medications less often, except occasionally to help patients sleep more restfully.

Traumatized patients tend to like tranquilizing drugs, benzodiazepines like Klonopin, Valium, Xanax, and Ativan. In many ways, they work like alcohol, in that they make people feel calm and keep them from worrying. (Casino owners love customers on benzodiazepines; they don't get upset when they lose and keep gambling.) But also, like alcohol, benzos weaken inhibitions against saying hurtful things to people we love. Most civilian doctors are reluctant to prescribe these drugs, because they have a high addiction potential and they may also interfere with trauma processing. Patients who stop taking them after prolonged use usually have withdrawal reactions that make them agitated and increase posttraumatic symptoms. I sometimes give my patients low doses of benzodiazepines to use as needed, but not enough to take on a daily basis. They have to choose when to use up their precious supply, and I ask them to keep a diary of what was going on when they decided to take the pill. That gives us a chance to discuss the specific incidents that triggered them.

A few studies have shown that anticonvulsants and mood stabilizers, such as lithium or valproate, can have mildly positive effects, taking the edge off hyperarousal and panic.⁵⁷ The most controversial medications are the so-called second-generation antipsychotic agents, such as Risperdal and Seroquel, the largest-selling psychiatric drugs in the United States (\$14.6 billion in 2008). Low doses of these agents can be helpful in calming down combat veterans and women with PTSD related to childhood abuse.⁵⁸ Using these drugs is sometimes justified, for example when patients feel completely out of control and unable to sleep or where other methods have failed.⁵⁹ But it's important to keep in mind that these medications work by blocking the dopamine system, the brain's reward system, which also functions as the engine of pleasure and motivation.

Antipsychotic medications such as Risperdal, Abilify, or Seroquel can significantly dampen the emotional brain and thus make patients less skittish or enraged, but they also may interfere with being able to appreciate subtle signals of pleasure, danger, or satisfaction. They also cause weight gain, increase the chance of developing diabetes, and make patients physically inert, which is likely to further increase their sense of alienation. These drugs are widely used to treat abused children who are inappropriately diagnosed with bipolar disorder or mood dysregulation disorder. More than half a million children and adolescents in America are now taking antipsychotic drugs, which may calm them down but also interfere with learning age-appropriate skills and developing friendships with other children.⁶⁰ A Columbia University study recently found that prescriptions of antipsychotic drugs for privately insured two- to five-year-olds had doubled between 2000 and 2007.⁶¹ Only 40 percent of them had received a proper mental health assessment.

Until it lost its patent, the pharmaceutical company Johnson & Johnson doled out LEGO blocks stamped with the word "Risperdal" for the waiting rooms of child psychiatrists. Children from low-income families are four times as likely as the privately insured to receive antipsychotic medicines. In one year alone Texas Medicaid spent \$96 million on antipsychotic drugs for teenagers and children—including three unidentified infants who were given the drugs before their first birthdays.⁶² There have been no studies on the effects of psychotropic medications on the developing brain.

Dissociation, self-mutilation, fragmented memories, and amnesia generally do not respond to any of these medications.

The Prozac study that I discussed in chapter 2 was the first to discover

that traumatized civilians tend to respond much better to medications than do combat veterans.⁶³ Since then other studies have found similar discrepancies. In this light it is worrisome that the Department of Defense and the VA prescribe enormous quantities of medications to combat soldiers and returning veterans, often without providing other forms of therapy. Between 2001 and 2011 the VA spent about \$1.5 billion on Seroquel and Risperdal, while Defense spent about \$90 million during the same period, even though a research paper published in 2001 showed that Risperdal was no more effective than a placebo in treating PTSD.⁶⁴ Similarly, between 2001 and 2012 the VA spent \$72.1 million and Defense spent \$44.1 million on benzodiazepines⁶⁵—medications that clinicians generally avoid prescribing to civilians with PTSD because of their addiction potential and lack of significant effectiveness for PTSD symptoms.

THE ROAD OF RECOVERY IS THE ROAD OF LIFE

In the first chapter of this book I introduced you to a patient named Bill whom I met over thirty years ago at the VA. Bill became one of my longtime patient-teachers, and our relationship is also the story of my evolution of trauma treatment.

Bill had served as a medic in Vietnam in 1967–71, and after he returned, he tried to use the skills he had learned in the army by working on a burn unit in a local hospital. Nursing kept him frazzled, explosive, and on edge, but he had no idea that these problems had anything to do with what he had experienced in Vietnam. After all, the PTSD diagnosis did not yet exist, and Irish working-class guys in Boston didn't consult shrinks. His nightmares and insomnia subsided a bit after he left nursing and enrolled in a seminary to become a minister. He did not seek help until after his first son was born in 1978.

The baby's crying triggered unrelenting flashbacks, in which he saw, heard, and smelled burned and mutilated children in Vietnam. He was so out of control that some of my colleagues at the VA wanted to put him in the hospital to treat what they thought was a psychosis. However, as he and I started to work together and he began to feel safe with me, he gradually opened up about what he had witnessed in Vietnam, and he slowly started to tolerate his feelings without becoming overwhelmed. This helped him to refocus on taking care of his family and on finishing his training as a minister. After two years he was a pastor with his own parish, and we felt that our work was done.

I had no further contact with Bill until he called me up eighteen years to the day after I first met him. He was experiencing exactly the same symptoms—flashbacks, terrible nightmares, feelings that he was going crazy—that he'd had right after his baby was born. That son had just turned eighteen, and Bill had accompanied him to register for the draft—at the same armory from which Bill himself had been shipped off to Vietnam. By then I knew much more about treating traumatic stress, and Bill and I dealt with the specific memories of what he had seen, heard, and smelled back in Vietnam, details that he had been too scared to recall when we first met. We could now integrate these memories with EMDR, so that they became stories of what happened long ago instead of instant transports into the hell of Vietnam. Once he felt more settled, he wanted to deal with his childhood: his brutal upbringing and his guilt about having left behind his younger schizophrenic brother when he enlisted for Vietnam, unprotected against their father's violent outbursts.

Another important theme of our time together was the day-to-day pain

Bill confronted as a minister—having to bury adolescents killed in car crashes only a few years after he'd baptized them or having couples he'd married come back in crisis over domestic violence. Bill went on to organize a support group for fellow clergy faced with similar traumas, and he became an important force in his community.

Bill's third treatment started five years later, when he developed a serious neurological illness at age fifty-three. He had suddenly started to experience episodic paralysis in several parts of his body, and he was beginning to accept that he would probably spend the rest of his life in a wheelchair. I thought his problems might be due to multiple sclerosis, but his neurologists could not find specific lesions, and they said there was no cure for his condition. He told me how grateful he was for his wife's support. She already had arranged to have a wheelchair ramp built to the kitchen entrance to their house.

Given his grim prognosis, I urged Bill to find a way to fully feel and befriend the distressing feelings in his body, just as he had learned to tolerate and live with his most painful memories of the war. I suggested that he consult a body worker who had introduced me to Feldenkrais, a gentle, hands-on approach to rearranging physical sensations and muscle movements. When Bill came back to report on how he was doing, he expressed delight with his increased sense of control. I mentioned that I'd recently started to do yoga myself and that we had just opened up a yoga program at the Trauma Center. I invited him to explore that as his next step. Bill found a local Bikram yoga class, a hot and intense practice usually reserved for young and energetic people. Bill loved it, even though parts of his body occasionally gave way in class. Despite his physical disability, he gained a sense of bodily pleasure and mastery that he had never felt before. Bill's psychological treatment had helped him put the horrendous experience of Vietnam in the past. Now befriending his body was keeping him from organizing his life around the loss of physical control. He decided to become certified as a yoga instructor, and he began teaching yoga at his local armory to the veterans who were returning from Iraq and Afghanistan. Today, ten years later, Bill continues to be fully engaged in life—with his children and grandchildren, through his work with veterans, and in his church. He copes with his physical limitations as an inconvenience. To date he has taught yoga classes to more than 1,300 returning combat veterans. He still regularly suffers from the sudden weakness in his limbs that requires him to sit or lie down. But, like his memories of childhood and