

Trauma & the Body

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I would like to begin by expressing my gratitude to my recently deceased colleague, Dr. Maryanna Eckberg (1999), director of clinical services at the Healing Center for Survivors of Political Torture, Berkeley, California. Her clinical work, her counsel and her writings have been very important to me.

To make this even more of a group experience let me note that Dr. Swiller incorrectly transcribed the title I gave him over the phone. My title is Trauma and the Body- Hillel's is: Psychic Trauma and the Body. He did this, in my opinion, because in a mortal moment he succumbed to the same mind/body conundrum that confronts us when we work with traumatized patients and with which I will be struggling this morning.

While Dr. Swiller is noting what is going on in his body, let me speak to the conundrum. Hillel is, of course, in part correct: the word "psychic" at first seems necessary because we are not talking about broken bones or circulatory collapse per se- these are more the purview of the surgeon and internist. On the other hand, our topic IS about the traumatic impact on the person whose arm or pelvis was fractured. What I will be stressing today is that referring to this impact as "psychic" does not do justice to the large body of research documenting that overwhelming experience is actually often registered, encoded, and retrieved on a body-that is, sensory-motor-affective level. Pierre Janet (1920) first described dissociation as the central mechanism people used to cope with unbearable experiences. He taught us that sensations, affective states and behavioral enactments are the language of traumatic memory. Today van der Kolk (1996), Schacter (1987), Siegel (1993), Perry (1997) are documenting how this state-dependent experience is "remembered" as a re-experiencing of the event, rather than as a narrative placed in time. Brain imaging now shows us Broca's area and the hippocampus grow dim, as the information is "remembered" associatively by brain stem areas that regulate our basic life functions. So a provocative, but perhaps accurate title for this talk might read, "an approach to "psychic" trauma that is not body-disoriented".

Now trauma can be a controversial topic. Just a few months ago - I believe it was in this Tuesday conference, while Dr. Richard Gartner was presenting on the much denied and understudied topic of the sexual abuse of boys, we barely avoided one more long and heated foray into the validity of memories of such abuse when they are recovered during a course of therapy. But the body in psychotherapy is perhaps even more controversial than the topic of trauma. This, I would suggest, is due to many issues that caused a painful rift between Freud and Ferenczi many years ago. I am sure I am oversimplifying and perhaps even worse, but I believe that mainstream psychoanalysis and psychotherapy have been concerned about directly involving the patient's body- its movement, sensation, touch- as opposed to its linguistic/fantasied representation. Physical movement by the patient has been discouraged...the famous somersault by Michael Balint's patient (1968,) was a notable exception. Patients were to remember, not to reenact. They were not to discharge libido that could be better channeled into symbolic, linguistically rendered narrative. Today, as I have already indicated, there is a lot of scientific data to suggest that you cannot desensitize/habituate state-dependent sensory-motor memories if you and your patient cannot gain access to them, anymore than you can teach someone to ride a bicycle by talking to them.

So why, when Bessel van der Kolk and Rachel Yehuda would very likely tell you that the patient's inchoate sensations and body movements **are the traumatic memory that is available**, why then are reasonable therapists still so concerned about bringing the patient's body directly into the consultation room? One big reason, I believe, is the concern about the potential for sexual abuse, misuse of the patient--undue familiarity is the legal term. We live in a litigious society. One can obviously seduce and misuse a patient in untold ways, but it simplifies matters to be able to say to the judge or your supervisor for that matter, "I never laid a finger on him/her".

About two months ago, in our Tuesday conference Al Fay recounted a colleague's statement of some twenty-five years ago, to the effect that no meaningful dialogue could occur between psychoanalysts and cognitive behavior therapists, because their respective vocabularies and underlying assumptions were so vastly disparate. My sense is that this is, if possible, even more the case when it comes to reasonably mainstream verbal psychotherapy and just about any kind of body-oriented psychotherapy (some might even argue that this term is an oxymoron; how does somatopsychic therapy sound?)

VIGNETTE 1

In the spirit of trying to reduce this putative paradigmatic gap, let me relate a first clinical vignette that occurred about twenty-five years ago when, as you shall hear, I laid more than a finger on my patient. Please note that before I touch a patient, I ask their permission and we establish a verbal and nonverbal "stop" signal should the contact at any point begin to feel not right. My patient whom I shall call Kate, was in her late twenties, a rather withdrawn person who lived in a commune, made poor eye contact, and spoke of feeling a kinship with the "eye / I" at the center of the universe. This was at a time in my young career before sexual abuse and true and false recovered memories thereof were such prevalent topics. We had been working for several months, when one day, as she lay on her back on the day bed and I sat next to her, she spoke softly of her "cosmic loneliness." I then rested my hand on her forearm for five or ten minutes...during which time Kate was silent. She then spent the next forty minutes telling me about the awful sexual abuse that she had been subjected to by her stepfather. I was the first and only person that Kate had told about the abuse. She had spoken to no one of it, neither during the ten years that it went on, nor in the fifteen years since. I was deeply touched and not a little shocked by the session and by Kate's story.

I will not forget something else that Kate said in that same session: she said that the safety and rightness (this is not verbatim- but it was the gist of it) which she felt in my touch had somehow almost instantly both reduced the shock of what had numbed her mind and body, and also given her a new experience. What I understood her to mean by this was that she had recognized in the safe touch of a male-caregiver what had not happened to her, and, therefore what had actually happened!

I think I chose this vignette because it seemed to work out well. Kate felt that it was a crucial step in her healing process, but I think we had to stop the therapy several months later, before I could tell if her life had changed for the better in a sustained way. I am interested in two things here: I think the vignette is deceptively simple and raises all sorts of questions...and-I'm not sure how to manage the time- but I would like to hear your questions and vignettes...particularly on the challenge of trauma survivors who have no words for the unspeakable things which happened to them. Van der Kolk (1996, p.289) tells us that telling their whole story in words does often not help such patients. The language of their state-dependent memories (Perry 1997) is silence, sound, tachycardia, bradycardia, and so forth. My touch seems to have offered Kate a bridge to a verbally encoded, integrated narrative. Her own shame/guilt over her physical pleasure, and her stepfather's mix of kindness during the sexual contact, and threat of violence if she told anyone--seems to have left her unable to grasp the reality of the violation. But was the touch really worth so many words? Was it a necessary and sufficient condition for her to reorganize so much experience - and so quickly - maybe even quicker than EMDR? I seem to have both accessed and reduced her dissociation. But with no apparent history of a male caregiver's safe touch, how did she "recognize" my safe touch, as opposed to having to learn about it over an extended time. Kate's response certainly suggests that she had experienced and internalized secure, safe touch from a caretaker prior to the onset of the abuse. And suppose she had felt my touch as unsafe, and been re-traumatized by it? In this regard, nowadays I take a careful history, especially regarding abuse...and attempt to let the level of trust and solidity of the therapeutic alliance inform my interventions. I also tried to do this twenty-five years ago, which, in addition to good luck, may have something to do with why I have never been sued during the 30 years of my practice. But there is room in this vignette for everyone to have the last word, because twenty-five years ago I may well not have asked Kate during the anamnesis if she had been sexually abused. There is, I believe, much to suggest that even if I had, she would not have been able to tell me.

If you find this material difficult to relate to partly because your patients do not bring you their unprocessed trauma in a sensory-motor language, we *could* be working with a very different patient population. Many of our patients select us because of what they hear about our approach. I think it would be helpful if you shared for a few minutes what you felt on a bodily, visceral level, as I spoke about putting not one, but five fingers - my whole hand - on Kate's arm. (We break for five minutes of sharing-to get a flavor of reactions.) My point here is that your judgments, your sensations might illuminate what your patients sense in you that prevents them from bringing in the sensory-motor language of their unprocessed trauma. Can you allow them to stay with body sensations/movements for which they have no words, or would such phenomena make you too uncomfortable to abide with them, and not encourage a premature translation into spoken language? Remember Lou Linn's story about his patients starting to dream in color when he began to do research on color dreams. Lou swears they had no way of knowing that this was his interest. Such, apparently, is our power to influence what our patients bring us.

Pierre Janet, Judith Herman, Bessel van der Kolk and most leading researchers in the field of trauma tell us of hearing from both children and adults that their traumatic experiences were initially organized on a nonverbal level. That is, they are initially experienced as fragments of the sensory components of the event

such as visual images, olfactory, auditory or kinesthetic sensations, intense waves of feeling, diffuse somatic sensations, and involuntary bodily movements. Interestingly, many of these survivors/patients, not unlike the therapists/researchers who hear their stories (for that matter, not unlike Sigmund Freud (1896)), they and we all struggle to know what if any of these fragments are traces of an actual original traumatic event, or events, which can be harnessed in the creation of a therapeutic narrative.

If you do not have a number of analogous vignettes from work with your traumatized patients, please ask yourself why not? If you do, I am very interested in how you deal with them.

VIGNETTE 2

My patient, Emily, a woman in her forties, functioned competently, but I thought well below her potential. Whatever she accomplished was accompanied by her pervasive self-denigration and loathing. She had a deep sense of herself as contaminated and therefore toxic to others. Her outward manner was accommodating and sweet to the point of apologizing even when others were in the wrong- she could see this clearly after the fact, but would react reflexively in a situation. She was never that far from sudden episodes of cold, withdrawn hatred, during which she felt "dead", and which could last from moments to months at a time.

Now during my work with Emily, she apparently felt free to experience something akin to what Janet and van der Kolk, and others have described in their patients way of "remembering" something overwhelming that has happened to them. I did not explicitly instruct her not to censor--that is to permit any bodily tensions, sensations, movements and so forth that might spontaneously occur as she lay on the day bed in my office.... one might say, to permit herself free access to her somatic associations. I believe this was not necessary because she sought me out knowing that my approach did not proscribe, or even value such phenomena less than spoken language.

At any rate, Emily began to go into episodes lasting between ten and thirty minutes, during which she would be flooded with panic and dread, scream "no" repeatedly, and twist and writhe and emit anguished sounds as one would who was being overwhelmed by an implacable, vastly superior force. No two episodes were the same, but they had this overall character. Frequent additional features included her having difficulty breathing, and also gagging and choking and attempting to brush something away from her face. Typically, after the episode, Emily might report that she had tasted semen in her mouth, and felt an incredibly intense "buzz" in her entire body, and a heat or excitation in her pelvis that was way beyond anything she could tolerate. As she put it: "I'd go mad if I couldn't turn it off". At times she would come out of the episode struggling to find language to express how unspeakably humiliated and defiled she felt. During the episodes I was always within a few feet of Emily, sitting on a chair next to the day bed. Often for some minutes, when she was not engaged in what looked like her futile attempts at escape, she would press her back against my arm, actively seeking physical contact. While at times she had flashes of being a child of about five in her father's car, Emily was maddened by a complete lack of images and/or any actual

memory of what this was all about. Over the course of a year, meeting approximately once a week, our progress was slow. In her everyday life, Emily's self-loathing frequently overcame her palpably artificial "niceness" and she then would go "dead" - that is, dissociate. If she seemed closer to being able to see/know what had happened, she moaned despairingly, "I'll lose everything."

Before I conclude this vignette, let me note that I do not believe there is great consensus, even among trauma experts, as to how to be therapeutic with a problem such as Emily's. There's a lot of data to support the therapeutic effect of being able to confide in a trusted and supportive significant other as soon as possible after trauma strikes. But this paper is about when the story is still too unspeakable to tell. When the story told is in words that are dissociated from a taste of semen, a sense of suffocating, a racing, pounding heartbeat, raw terror and an overwhelming betrayal...such a story is of no help in desensitizing, habituating the above state-dependent "memories". You cannot integrate that which you have no access to. Through her associated neuronal patterns of activity, once Emily's episode begins, it is likely that the red alert in her central nervous system has sounded at brain stem, midbrain, thalamic and limbic levels well before it is interpreted cortically. And then there is what Blaise Pascal (1670) taught us well before anyone knew about cortico-limbic-cortical subcircuits. He said: "the heart has its reasons which reason knows nothing of". So Emily's limbic system possibly in consultation with her anterior cingulate cortex is carefully titrating her access to the heart-breaking, crazy-making truth. There is also recent animal and human research (Pitman, van der Kolk, Orr and Greenberg (1990) Henry, (1996) to suggest that Emily is helped to cope with her chronic state of underlying hyper-arousal by periodically releasing her own endogenous opioids, and possibly the hormones prolactin and oxytocin. While these molecules are probably involved in mediating Emily's numbing and freezing responses, they, like norepinephrine, also interfere with the storage of and access to episodic memories that would allow her to remember more than she can bear.

Furthermore, Emily gets access to her state-dependent memories, that is to say, her lower brain centers are entrained in an all-or-none fashion that very probably has genetically wired, species-survival value. All this is to say that I was not sure if we were accomplishing something along the lines of exposure and desensitization of overwhelming sensation and affect, or merely re-traumatizing Emily by deepening the grooves of her neuronal and neurochemical activation patterns. Emily herself said the experience of having me in the room close to her, at times in physical contact with her, was vastly important as a secure anchorage and that she was both in the past experience and in the room with me in the present. I like to think she was not just telling me what I wanted to hear, but, as we know the dissociative ability to be in two places at once has its adaptive aspects and Emily may have been doing so in the service of healing her ego. If so, the healing was slow.

Then something interesting happened. During the episodes, Emily usually experienced her limbs, particularly her arms as impotent, often moving as she put it "ineffectively and purposelessly", On this particular day instead of her resting her back against my arm, and while she was still partly in her flashback or altered state, I suggested that Emily take hold of my forearms with her hands and hold them

firmly. She did so for about a minute, appearing extremely frightened initially, less so as the seconds went by. Her comment, as I recalled it after the session, was: "it was good that you could hang in [that you hung in and gave me directions] to know that I have a brain and can make movements and could see your eyes. I wish that I had a video of this session".

Next session Emily has something to tell me. She is aware of how cut off her hands are from the rest of her body. She often has felt numb, but this is different: all sensation ends above her wrists. Today, as she does about half the time, Emily is sitting in a chair. She sits silently looking furtively at her hands and moving them for ten or fifteen minutes. I encourage her to keep looking at her hands and feeling what she can of them. Then the word "perpetrator" comes to her - it seems to be about her and her hands. She speaks of an episode twenty-five years ago of which an old school friend recently tried to remind her over dinner. It seems that during this episode Emily went into the woods with a boy from her class and they both undressed: "I must have been so curious", comments Emily. But at dinner with her friend, she at first had no memory of the incident, and then threw up her food as the memory came back. Why, she thought leaving the restaurant did I so overreact to such a relatively innocent incident? Back in our session, Emily then asks for a blanket and covers herself for another ten or fifteen minutes - during which, she later says, she was unable to say the words which "swelled" inside her body-she finally uncovers, and looking at her hands, says: "I feel I must have touched- fondled someone's genitals". In the next minute she feels an admixture of shame, delight and being bewitched. I ask her if she can continue to look at her hands. "That feels punishing," she says, "like rubbing your nose in it...face the instruments of your crime." Emily sits on her hands, and continues: "at first it was alright...I was fine..then I wasn't...I knew I had to make myself up...I mean become someone else...I died. But I still can't see a picture", she continues, still unwilling to look at her hands. "But this time it is different. I **know what happened!**...I'm sorry, I'm sorry, I'm sorry" she intones (this is an existential mantra of hers). "No wonder I always felt so guilty...I can almost hear my dad saying 'nothing happened...we'll just act like everything is o.k.'" Emily suddenly laughs in delight and makes a gesture with open hands and a facial expression that says: "so, well...I've been found out." The session ends with Emily moving her chair next to mine and putting her hand on mine, saying: "I need to feel that I am safe for you". The following session, perhaps anticipating your questions today, Emily comments, "I want you to know how crucial you are to this process, I mean telling me what to do with my hands...because when I lost my dad, I also lost myself." Emily is still in therapy with me. She still wants to explore what happened, and goes into her episodes, each time now getting a little closer to seeing the dreaded and elusive picture and being able to feel the depth of the heartbreaking betrayal of her love for her father.

Emily's life and symptoms improved considerably following the above detailed session. I believe that the purposeless quality of her arm movements was the immediate stimulus to my intuitive physical intervention. Depending on your explanatory model, your underlying assumptions, I may have been contaminating the transference for God knows what countertransference reasons, and while I was at it, reenacting Emily's traumatic experience. I submit that I was actually providing a human bridge across which Emily could begin to experience being in charge both of her mind- in its ability to attend and focus,

and of her bodily responses. Crucial here is that this was occurring while she was still in touch with the traumatic experience that, consequently was being renegotiated and integrated. I further submit that Emily was also reorganizing on a cognitive level. Her initial retelling of our hands-on interaction was linguistic, but also rather anchored in the here and now of her sensory-motor experience.

"It was good that you could hang in [that you hung in and gave me directions] to know that I have a brain and can make movements and could see your eyes. I wish that I had a video of this session."

With escape impossible and not enough resources to fight, Emily needed to reorganize her experience of frenzied, unfocused activity. Actually, the sensation and movement in and of her arms and hands **were her implicit or perceptual memory**. *By encouraging her use of her hands and eyes in a focused task, we were stimulating her focal attention*. Explicit memory, you will remember, requires focal attention to incoming stimuli. I believe that having me with her (her words again: "thanks for hanging in there with me") was "contaminating" her traumatic transference in a helpful way. It was reducing the high state of arousal mediated by Emily's amygdala to a level where incoming stimuli could be processed and remembered by her hippocampus, thus making focal attention possible. But this was all quite nascent and I understand Emily's sudden desire for a video of the session as reflecting her awareness that the rehearsal process between her hippocampus and her cortex had not taken place over sufficient time (weeks, months) to securely place this new information in her explicit, declarative, narrative memory.

Although I clearly did not anticipate this, I further believe that our hands-on interaction led directly to the depersonalization/dissociation of her hands that had had very specific kinesthetic and tactile, state-dependent memories stimulated. In the following session, using the sensory-motor information in her hands and looking at them, Emily, for the first time, consciously encoded in words a crucial part of the abuse at the hands of her father - but in this instance involving her own hands. This seemed critical in freeing her from an unconscious, subcortical confusion as to who was the real perpetrator; she now had a memory- part of a linguistic narrative from a time and place in her life.

I also want to stress how slow Emily's process was during this session. When she spoke, she did so in very slow motion. Before she spoke her most difficult words, she spent perhaps fifteen minutes staying with the strange anesthetic sensation in her hands, and with my encouragement examining them. She even created a private space for herself under a blanket for another ten or fifteen minutes while, as she put it, "the words swelled inside my body...I so didn't want to say them". She was finally beginning to speak her story.

VIGNETTE 3

My third and final vignette concerns Lucia, a European woman of thirty, whose childhood and adolescent abuse occurred in the form of sexual betrayal, primarily by her mother, and more passively, by her father. Lucia, like Emily, was self-selected, i.e., she said she came to work with me specifically because she wanted an approach that would directly address what was going on in her body. She related the following to me during our initial interview. When she was seventeen years old, her mother "set her up" with her mother's "friend", a wealthy man of sixty-seven. Lucia suspects that her mother had been interested in this man before she married, but that she had not been young enough or attractive enough for him. Her mother claimed that this relationship would help Lucia—that since this man had power and wealth, good things would come of it. Lucia was horrified. She remembers telling herself, "I trust my momma, she couldn't do this to me, there must be a reason." Her parents were separated, and she did not feel she could turn to her father for help. She flew to another city, and spent three days with this man, as she did every weekend for the following year. After the first month, she missed her period and told her mother, who looking at her in amazement, asked: "why did you have sex with him? Lucia shouted back (perhaps for the only time in her life): "what do you think?" Lucia became depressed and made two suicide-attempts - once with pills and once cutting her wrist, about which she says, "they were not dangerous, I wanted attention." Lucia's bulimia dates from this period and (along with an inability to sustain an intimate relationship) was her presenting complaint when we began to work three months ago. Two years ago Lucia ended an eleven-year relationship with a man who, she always hoped, would be her life partner; he demanded ever more perversity in their sex-life, and this was so normal for her that it took her ten years to realize she was being used.

Lucia told me all this in a detached manner...her tone of voice and the look in her eyes were remote and dream-like. In fact, this seemed her basic, baseline way of being in our sessions. She was from a country where emotional intensity is something of a cultural norm, but in between her lively greeting and goodbye, Lucia would settle into this distant demeanor; it was much more dissociated than depressed. As a body-oriented therapist, I probably pay particular attention to where I feel the resonance in a person's voice is coming from in their body; I sense this by the resonance that it sets up in my body. This may not be all that different from how any therapist pays attention to what emotions, thoughts and states he or she experiences in a projectively identified way in the presence of his or her patient.

Lucia's voice had no resonance, no timbre. It was disembodied, ghost-like. I asked her what she felt while she told me of this terrible betrayal. "Nothing", she replied. I then asked Lucia, if she were told this same story by a friend, what she imagined the friend would be experiencing: "I would be surprised that she's not lost her mind." said Lucia. "She would probably want to kill her mom to teach her a lesson."

So what do you think I did next? What might you have done? Probably a number of approaches in the right hands could help Lucia with the numbing and frozenness that seemed to be protecting her from a loss of control into insanity and murderousness. Certainly seeing if she could get closer to her inner experience of betrayal by linguistically encoding it, that is, by talking about it, via the device of her imaginary friend, seems reasonable. I tried this, but did not seem to get Lucia close enough to the state-dependent

experience which, I tend to assume, Lucia must access if she is to desensitize or habituate the overwhelming affect involved. Now while Hillel will attest to the likelihood that I just wasn't skilled enough at the talking cure, I believe there was an even more basic reason. Lucia's spoken language was uncoupled from feeling by her chronic dissociation. Once again, because it bears repeating, one cannot habituate emotions or affective states that are not felt (Briere, 1995). One cannot get habituated to dissociated feelings that one does not experience (Gartner 1999). **So what I did was to ask Lucia to take a full breath in and to vocalize her exhalation.** Why did I do this and what happened next?

To render my intervention more pedestrian and familiar to you, let me reference a conference led by Sylvia Boorstein in which she led us through an induction to a meditative state. She had us breathe deeply and attend to our internal sensation and experience. Although she was guiding us towards a wiser, spiritual state, it made sense to me that our path consisted in attending to our respiration. For thousands of years healers of various cloths have attended to breathing- a bodily function which is regulated at a brain-stem involuntary level but which can be influenced at thalamic, limbic and even cortical levels. I doubted that Lucia could actually breathe abdominally the way Herbert Benson (1975) suggests we do when we want to relax. She was frozen stiff in the combined state of chronic hyper-arousal and numbed immobility which Herman, van der Kolk and most trauma researchers have described. Indeed, when Lucia tried to inhale fully, her abdomen contracted rather than expanding outward; we body-oriented therapists call this *paradoxical breathing*. Lucia's diaphragm, chronically contracted in a state of shock, did not move downward during inhalation sufficiently to displace her abdominal organs. In an attempt to compensate for her relatively shallow respiration, Lucia's shoulders moved up towards her ears as she inhaled with her accessory muscles of respiration. As part of a deepening awareness of how she has embodied her past experience, Lucia noticed that she, that is, her body, was organized in a position of fear (demonstrate). Regarding the underlying assumptions that would make me attentive to whether a patient could relax enough to take a deep breath or make a sound, there was the matter of people tending to encode and therefore having to retrieve traumatic experience on sensory-motor-affective levels. But there is an even broader assumption from which body-oriented therapists tend to operate, and for which, I believe, Daniel Stern (1985) recently gave a compelling developmental argument. In contrast to the developmental schema of Anna Freud (1965) in which symbolic language becomes the privileged, I believe the correct word is "appropriate", mode of adult communication, Stern (1985) delineates early domains of self- he calls them emergent, core and inter-subjective-which exist basically at a body level. "Once formed, the domains remain forever as distinct forms of experiencing social life and self. None are lost to adult experience."(1985, p.32) **The point here is that they are never subsumed by, adequately grasped or rendered by our verbal selves.**

As if the breath were not enough, why the tone? Therapists of whatever cloth agree that we have no more valuable therapeutic skill than listening well to our patients. At times, in trying to listen well, I think I try to do what aphasic people do naturally. Or at least what Oliver Sacks (1987) says his aphasic patients do in his sketch called "the President's Speech" from his volume, "the Man Who Mistook his Wife for a Hat". Although their neurological deficit leaves them unable to understand words as such, Dr. Sacks' patients

nonetheless understand most of what is said to them. These patients have compensated for their loss by developing a heightened sensitivity to the tone, color and expressiveness in which language is normally suffused. Such is their enhanced resonance to what Dr. Sacks calls "emotionally-laden utterance" (p.81), that they may fully grasp its meaning even when every word is missed. Sacks' point is that "one cannot lie to an aphasic. He cannot grasp your words, and so cannot be deceived by them" (p.82).

So also says Mr. Rogers: "Kids can smell a phony a mile away."

Thus we have this apparently mixed group: aphasics, dogs, young children of a certain age, perhaps fools of any age, Frieda Fromm-Reichman when she first came to this country, and finally body-oriented therapists. Actually we try to retain our understanding of words **AND** to listen to the tone-color, the timbre, the vocal nuance and whatever other nonverbal aspects of our patient's expression we are able to attend to. So, just as I might have pointed out to a patient that he never spoke about his relationship to his father, thereby inviting him to do so, I pointed out to Lucia that her words seemed spoken in a voice that lacked feeling-tone; neither she nor I could feel them. And I invited her to directly try to find the voice that she had lost.

So she breathed out, but with no tone. She then said, "I don't make sounds", and went on to tell me the following incident: when she was five years old, Lucia's mother took her along for the day which she spent with her lover (a cousin of Lucia's father). Lucia fell asleep in the back of his car while her mother and the man were in the park nearby. The two of them awakened her as they were about to have sex in the front seat. Her mother was initially a bit concerned that Lucia would awaken, but Lucia apparently convinced them both that she was still asleep and they proceeded. As Lucia and her mother returned home at the day's end, her mother told her to say nothing or she would kill her (I asked more about this, but Lucia was not clear whether she understood the difference between being killed or being dead to her mother). When she finished this narrative, Lucia was silent for a while and then summarized what she had offered as an explanation for why she does not make sounds. Her comment was, "after that I told them (my parents, everybody) what they wanted to hear". My body-oriented third ear understood Lucia to be saying 'the effect of this incident was that I no longer made sounds that were true to me...I lost my voice; neither my words nor the breath and sound I utter them with are truly mine.'

So when she was five, Lucia learned that if her words conveyed the truth of what she knew and felt, she would be abandoned or annihilated by her primary attachment figure (her father was always distant and uninvolved). I spoke earlier of children of a certain age who like aphasics, not understanding your words, cannot be deceived by them. According to the Attachment researcher Mary Main (1991), such a child would have to be young indeed, not understanding many more words than the aphasic. Main and her colleagues find that a majority of three-year olds can indeed be lied to because they grasp the words but not that the words can be used to misrepresent reality. However, by five or six years of age a majority of children can use words to make their parents believe things that are not true!

But poor Lucia could hardly have fully understood what she had participated in that was so wrong, so dangerous that to utter a word of it would cost her her life. Lucia herself identified this as a key moment when she might have lost her mind. When your life is threatened, Dr. Bruce Perry (1997) tells us that brainstem catecholamine systems mediate an almost instantaneous alarm reaction. I was not there to check Lucia's heart rate or the size of her pupils, but permit me the reasonable assumption that within milliseconds her hyper-arousal, hyper-vigilance and startle response were in place, and by the time the alarm reaction reached thalamic and limbic levels she began to feel terrified. There was no effective response possible since she needed her primary attachment figure. She had barely comprehended the situation before she became overwhelmed by the alarm reaction that was etching the traumatic memory in her nervous system. Mercifully, Lucia's endogenous opioids made it easier for her to go numb and float away into dissociation, as she lay on the back seat of the car.

Lucia has had four or five sessions with me since her voiceless exhalation. Very slowly and with my support, containment, and encouragement she has emitted or uttered some of her sound. In each session she is frightened that any loss of control of the volume and tonal fullness of her voice could unleash the crazy, murderous person she harbors within. Each time she is deeply relieved to note that she can reorganize, as Daniel Stern might say - and I would definitely say - **on a core bodily level, how much of herself it is possible to share inter-subjectively - that is, how much of herself she can have back and still be in relationship.**

Her reorganization is a work in progress- since she has found more of her sound, Lucia spontaneously takes deep breaths every few hours during her week. She has also had several transient episodes of loss of balance shortly after the sessions: Paul Schilder (1950) described this kind of somato-psychic imbalance as, "a particular type of dizziness. Dizziness occurs always when the impressions of the senses cannot be united" (p. 113). Several days after her initial vocalization, Lucia confronted her business partner in a direct and confident manner. Also, after she opened her voice more fully, Lucia remembered realizing that she "went to the edge of crazy in my mind" as a child. If she wants access to that material in the pursuit of feeling more present and alive, we might, when she has a stronger sense of self, carefully explore her current sensations in her here and now body, as she remembers the loud noises, flashing lights and sound of her heart racing and pounding she experienced at the time.

Finally, I do not assume, as some of you with a psychoanalytic perspective may, that because an exchange between a patient and myself involves physical touch, that I am merely "gratifying" the patient. How they actually experience the touch can be, as it was for Kate and Emily, part of their discovering how the past has affected their capacity to relate and part of their mastering traumatic material by directly reworking it in live interactions with the therapist.