Journal of Trauma & Dissociation, 10:204–218, 2009

ISSN: 1529-9732 print/1529-9740 online
DOI: 10.1080/15299730802624569

Routledge
Taylor & Francis Group

"That Part of the Body is Just Gone": Understanding and Responding to Dissociation and Physical Health

TERRI J. HAVEN, MSW
Private Practice, West Springfield, Massachusetts, USA

The past 2 decades have brought a significant surge in interest and research regarding the ways in which psychological trauma relates to the physical body. Researchers now understand a great deal about how the brain and the body process traumatic experiences, as well as the increased likelihood of an array of physical health consequences associated with both childhood and adult trauma and posttraumatic stress disorder. Experts are increasingly challenging mind–body dualism through solid theoretical and clinical bases for the central importance of listening to and communicating with trauma clients' bodies as part of reducing the suffering and long-lasting consequences of trauma. This article integrates this growing body of knowledge through a particular focus on trauma-induced dissociation and the implications of the physical and neurological processes and consequences of dissociation on clients' ability to participate in caring for their own bodies. The author utilizes an in-depth clinical example of expanding relational trauma psychotherapy to include a focus on working directly with trauma-related sensorimotor and physiological sensations and patterns.

KEYWORDS trauma, PTSD, dissociation, psychological trauma and health, psychological health and the body, relational trauma psychotherapy, sensorimotor psychotherapy

Received 3 March 2008; accepted 7 October 2008.
Address correspondence to Terri J. Haven, 117 Park Avenue, Suite 202, West Springfield, MA 01089. E-mail: tjhaven@gmail.com

John[1] and I first met 3 years after he was violently and randomly attacked outside his home while walking to the store for cigarettes. He suffered severe injuries to his torso and was left with debilitating physical and psychological scars. Unfortunately, for those 3 years after the attack, John had received very little professional psychological support and had relied on psychiatric medications and his primary coping strategy of dissociation to survive. When we first met he sat very rigidly with his arms by his side, basically moved only his eyes, blinked frequently, and spoke in very short sentences.

When I asked about John's reasons for coming to therapy, he replied, "I don't know what else to do; they won't give me my meds if I don't come and you're the only person who would see me." In response to my inquiry about how life was different since the attack, John said, "My chest and back are just gone" and "I can't do anything or go anywhere anymore." Throughout this article, I invite you into several crucial parts of my evolving psychotherapy process with John to consider both the psychological and physical consequences of dissociation for complex trauma survivors.

TRAUMA AND THE BODY

There has been a tremendous surge in interest and research over the past two decades regarding the ways that psychological trauma relates to the body. Van der Kolk's (1994) seminal article, "The Body Keeps the Score," first signaled a shift in attention from a primary focus on the psychological to the neurobiological and the body in traumatic stress. Since then there have been enormous strides in how the brain and the body process traumatic experiences (see Van der Kolk, 2006, for a current, in-depth review of the clinical implications of neuroscience research). The physical health effects of traumatic events and experiences are also now receiving increasing research attention in the medical literature. For example, in the classic Adverse Childhood Experiences Study, Felitti and colleagues (1998) found that childhood trauma was associated with increased likelihood of adult cancer, ischemic heart disease, chronic lung problems, and other conditions that had no known or direct etiological basis in the childhood events. Allen (2001) recommended conceptualizing posttraumatic stress disorder as a chronic physical illness, using diabetes as a paradigm and providing education about self-care as a foundation. In addition to bringing together an array of meaningful contributions in the field of trauma and health, Schnurr and Green (2004), in a recent edited volume, proposed a model that explains the association of traumatic events and poor physical health through psychological, biological, attentional, and behavioral mechanisms and stressed the importance of an integrated approach to care.

The dualism of mind and body also continues to be challenged with major contributions such as *Waking the Tiger* (Levine, 1997), *Splintered Reflections* (Goodwin & Attias, 1999), *The Body Remembers* (Rothschild, 2000), *The Body Bears the Burden* (Scaer, 2001, 2007), *The Trauma Spectrum*: *Hidden Wounds and Human Resiliency* (Scaer, 2005), and *Trauma and the Body: A Sensorimotor Approach to Psychotherapy* (Ogden, Minton, & Pain, 2006). All of these authors, while traveling very similar paths albeit with slightly different focuses, present solid theoretical and clinical bases for the central importance of listening to and communicating with trauma clients' bodies as part of reducing the suffering and long-lasting consequences of trauma.

In previous work (Haven, 2002; Haven & Pearlman, 2004), I considered the importance of including attention to clients' bodies, particularly their physical health, within relational trauma psychotherapy and the role of dissociation in impacting both clients' and therapists' awareness and discussion of physical health. In building on that work, this article focuses not only on the consequences of dissociation of mental functions, but in particular on the physical and neurological processes and consequences of dissociation on clients' ability to participate in caring for their own bodies.

DEFINING AND UNDERSTANDING DISSOCIATION

The field has made tremendous strides and yet continues to face several challenges in efforts to further operationalize the working definitions of trauma-induced dissociation. Most recently, DePrince and Freyd (2007) provided an excellent in-depth discussion of the varying dimensions and considerations over the past two decades, the current state of the art, and the challenges for the future in regard to the evolving definitions and understanding of dissociation. DePrince and Freyd suggested that a dialectical view of dissociation may help resolve issues of the adaptive–maladaptive nature of dissociation: "Dissociation may be both a creative adaptation to an environmental insult that threatens survival . . . and a deficit that causes problems in other domains of life . . . that invokes the importance of examining context" (p. 139). These authors stressed the importance of continued work to "examine differences in pathological versus nonpathological views of dissociation . . . to not exclude relevant phenomena . . . to untangle the complicated picture of comorbidity between dissociation and other forms of trauma-related distress" (pp. 146–147).

My central understanding of dissociation has been informed by a relational trauma framework, in particular constructivist self-development theory (for detailed discussions of constructivist self-development theory, see McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995; Saakvitne, Gamble, Pearlman, & Lev, 2000). Increasingly as I have come to expand the psychotherapy process related to dissociation to include the body, the context of freezing

and tonic immobility (Allen, 2001; Foa, Zinbarg, & Rothbaum, 1992; Levine, 1997; Nijenhuis, Vanderlinden, & Spinhoven, 1998; Ogden, Minton et al., 2006) and the neurological functions of the brain in imprinting and processing trauma (Ogden, Minton et al., 2006; Van der Kolk, 2006; Wylie, 2004) have also become invaluable.

Constructivist self-development theory understands dissociation within the context of self-capacities or inner abilities to regulate internal psychological processes and experiences. (See Pearlman, 1998, for an in-depth discussion of self-capacities.) These capacities include the ability to regulate affect, maintain a sense of positive self-worth, and maintain an inner sense of connection to benign others; they are developed in the earliest relationships with central caregivers or attachment figures. When those important others are not attuned to the child, are physically or emotionally absent, or are abusive, the child's self-capacities are not adequately developed (Haven & Pearlman, 2004).

In adulthood, individuals with inadequately developed self-capacities struggle to tolerate or modulate their feelings. An often familiar solution to this struggle for many survivors is *dissociation*, a response to potential or experienced danger that disconnects feelings, whether the source is internal or external. Pearlman and Saakvitne (1995) explained the central importance of understanding dissociation both as an intrapsychic defense and, in psychotherapy, as an interpersonal process:

> Phenomenologically, it is the separation of mental systems that would ordinarily be integrated. It represents the severing of connections among mental contents and categories that would otherwise elaborate and augment one another. Theoretically, it provides the therapist an invaluable framework for understanding a range of intrapsychic and interpersonal occurrences in psychotherapy with trauma survivors. (p. 120)

Pearlman and Saakvitne continued (further referenced and applied by Haven & Pearlman in 2004) by defining the intrapsychic functions of dissociation as follows: (a) to separate oneself from intolerable affects, reflecting the *need not to feel*; (b) to separate oneself from traumatic memories and knowledge, reflecting the *need not to know*; (c) to separate from unacceptable aspects of oneself, reflecting the *need not to be oneself*; and (d) to separate from the interpersonal relationship, reflecting the *need to manage the threat that connection poses*.

John's use of dissociation as understood through this lens first came to light very early in our work together. He had been denied disability, had no means of income, and needed my assistance quickly to complete the necessary appeal paperwork. Completing the disability forms also was the first way that we discussed or even acknowledged John's body, as the questions required very detailed information in terms of his history, his daily activities, and his physical abilities/limitations. It was also primarily the only way John participated verbally in our early sessions.

Therapist: John, what does it feel like for us to be filling out these forms together? I'm aware that we're discussing some very private parts of your life before we really have a chance to get to know each other.

John: It doesn't really feel like anything. It's just there and needs to be done . . . that part of the body is just gone since it all happened anyway.

Therapist: John, what do you mean "gone"?

John: Haven't seen it and don't talk or think about it—just want to answer the questions they have to know, okay?

Therapist: Of course, John. Maybe another time we can try to understand more about part of your body being gone and not feeling like anything—would that be okay?

John: Maybe, but it won't do any good. You're really saving me though by doing this paperwork.

John needed *not to feel* the intensity of emotions related to his trauma, *not to know* the consequences for his body, and *to manage our relationship* through a fragmented focus on "idealizing" me as his savior. As that session came to an end:

Therapist: John, as we've worked on this application today I've noticed that your breathing became more shallow. This process is complicated, isn't it?

John: Yep. Kind of nervous.

Many trauma therapists have come to understand that dissociation is "contagious"; when a client is unaware of something, it is often difficult for the therapist to bring it to mind or keep it in his or her own awareness (Davies & Frawley, 1994; Haven, 2002; Haven & Pearlman, 2004; Pearlman & Saakvitne, 1995; Saakvitne et al., 2000). In that session with John, I was aware of feeling an unusual amount of anxiety within myself as he and I made our way through the questions on the application. I understood myself to be holding much of John's affect and therefore focused on broadening his awareness of his change in breathing in my efforts to help reduce his "nervousness." I didn't "remember" that his lungs had been seriously injured in the attack and that he used smoking cigarettes as a way to self-medicate and manage stress. I *needed not to know* about the horrible things that had been done to John's body or to consider the ways his body might still be impacted in the present moment.

THE EARLY PROCESS

For about the first year John and I saw each other weekly. He was unable to drive and depended initially on his elderly mother for transportation. His sense of terror and shame coupled with his mother's health issues limited John's ability to travel outside his home other than for medical appointments or to

obtain basic necessities. Much of that first year our process focused on safety and stabilization, with a great deal of psychoeducation and the evolving development of a positive attachment within the therapeutic relationship. Gradually, John began to speak a little more, particularly as I showed gentle but consistent interest in and modeling of his safety and self-care and as we were successful in our appeal for disability benefits and subsequently adding an outreach support worker to our provider team.

Several months into therapy John began to have severe cuts across his hands and arms. In exploring these injuries with John, I learned that he was diligently trying to "save" a stray cat that had taken up residence outside his apartment and that he was letting the cat "play" roughly by attacking his hands and arms as his way of "showing the poor thing that he can trust me . . . he doesn't have anybody else." John became very focused on taking care of the cat (now named Star) and talking with me about the importance of taking the process with Star very slowly and "never giving up even if he takes a long time to trust coming inside." John initially had no conscious connection to any physical pain related to the cuts from such rough play with Star. However, over time he responded well to my concern for balancing his safety while supporting his goal of gaining Star's trust and eventually purchased thick gloves to protect his hands until Star stopped using his claws in that way. John's relationship with Star became a central metaphor for our work together, and eventually the "safety nets" we developed related to his relationship with Star were able to be applied more directly to John's overall sense of safety, self-care, self-worth, and connection with his body.

FROM THE INTRAPSYCHIC TO THE PHYSICAL: FIGHT, FLEE, OR FREEZE?

As John and I continued to work together, I was increasingly struck by his repeated experiences of himself as unable to fight or flee and instead remaining frozen in actions, words, and bodily movements. Sitting with John did indeed on occasion bring to mind the phrase of a "deer in headlights." I understood that by definition a person who is traumatized has experienced an inescapable sense of inability to either fight or flee. However, only through deeper understanding of the growing trauma-related literature related to the limitations of the fight-or-flight response, animal defense, freezing, and tonic immobility (Allen, 2001; Foa et al., 1992; Levine, 1997; Nijenhuis, Vanderlinden et al., 1998; Perry, Pollard, Blakley, Baker, & Vigilante, 1995) did I begin to have a more useful context for understanding this particular presentation of John's dissociation (and his strong identification with the terrified and traumatized cat that eventually became his companion and roommate).

Peter Levine (1997) developed an approach to trauma treatment called *somatic experiencing* that focuses on the belief that trauma is "locked" in the body and must be healed by accessing it in the body. Levine believes that all animals, including humans, are physically programmed by evolution to flee, fight, or freeze in the face of overwhelming threats to life. He notes that in humans, however, when these natural responses to danger are thwarted and people are helpless to prevent their own rape, or beating, or car accident, the unfinished defensive actions become blocked as undischarged energy in the nervous system. People remain physiologically frozen in an unfinished state of high biological readiness to react to the traumatic event, even long after the event has passed. Levine describes trauma victims as having been totally helpless and unable to move—physically and psychologically—and stresses that they must regain in therapy that lost capacity to move, to fight back, to live fully in their bodies as much as in their minds.

In reviewing the limitations of the fight-or-flight response, Nijenhuis, Vanderlinden et al. (1998) cited evidence that only a minority of women report having actively resisted sexual and physical abuse or rape, inasmuch as they perceived action to be useless or dangerous. Instead, passive defenses such as freezing, paralysis, and retreating into fantasy predominate. These authors also found that clients with dissociative disorders often display three behaviors akin to freezing in animals, namely analgesia, anesthesia, and behavioral immobility (Nijenhuis, Spinhoven, Vanderlinden, van Dyck, & van der Hart, 1998). Misslin (2003, p. 58) described freezing as "alert immobility," where there is complete cessation of movement except for respiration and movement of the eyes (much like John's initial presentation in therapy).

Ogden, Pain, and Fisher (2006) noted that "these incomplete actions of defense may subsequently manifest as chronic symptoms" (p. 272). These authors continued by noting that "individuals may experience their fight and flight muscles held in a chronically tightened patterns, have heightened and unstable aggressive impulses, or have a chronic lack of tone or sensation in a particular muscle group" (p. 272). In considering these concepts of freezing and dissociation, Allen (2001) noted that "although the parallels between freezing and dissociation seem compelling, there is a crucial difference between them . . . dissociation entails disengaging from environmental stimuli . . . yet, the frozen animal is hypervigilant . . . freezing is a highly engaged, not detached, state" (p. 172). Allen continued by referencing Perry and colleagues' (1995) continuum of dissociative responses ranging from freezing to surrender, with surrender being consistent with tonic immobility, and emphasized the crucial focus on surrender as a better prototype for this aspect of dissociation.

At a point about a year and a half into our work and soon after we had increased sessions to twice a week, John and I spoke directly about the

evening he was attacked. His description aptly reflected a movement from a very hypervigilant state of "freezing" to a more immobile state of "surrender":

> *John:* At first I saw someone walking toward me and it seemed like he began to walk faster so I just focused all my attention on his feet and his hands, made sure I didn't look directly at his face. I thought about moving to the other side of the street but there wasn't time. Then he was just there on top of me. At first I tried to fight him, and get away, but there was nothing I could do. I remember I felt the knife in my chest and then all I know is that my whole body just stopped moving. I think he thought I was dead when he finally left. In some ways, I think I am dead.

This short but direct acknowledgement of John's experience of the physical attack came at a time in the therapy process when he had begun to experience a secure positive attachment within our therapeutic relationship and greater sense of safety to begin to at least imagine discussion of his experience of his body, specifically his experience of "that part of the body is just gone." Equally, if not more, important to the therapy was my own developing professional growth in understanding the "bottom up, not top down" neurobiological functions of the brain in imprinting and processing trauma (Ogden, Minton et al., 2006; Ogden, Pain, & Fisher, 2006; Van der Kolk, 2006; Wylie, 2004). John's ability to cognitively or emotionally process or reassociate with these injured parts of his body (or even be able to experience his torso as part of *his* body instead of *the* body) would only be able to reach a limited point until we first addressed his "here-and-now bodily experience of the traumatic past, rather than its content or narrative" (Ogden, Minton et al., 2006, p. 167) and strengthened his ability to self-observe and remain focused in the present moment versus returning to the familiar response of disconnection or dissociation.

FINDING THE DISSOCIATED BODY FROM THE BOTTOM UP

Van der Kolk studied brain images of patients with posttraumatic stress disorder that actually showed the occurrence of dissociation, the results of which suggested that "when people relive their traumatic experiences, the frontal lobes become impaired and, as a result, they have trouble thinking and speaking. They no longer are capable of communicating to either themselves or to others precisely what's going on" (Wylie, 2004, p. 39). Further neuroimaging studies Van der Kolk collaborated on have also shown that the executive functions of the brain become impaired when traumatized people try to access their trauma. Van der Kolk demonstrated that the imprint of the trauma does not sit in the verbal, understanding, part of the brain, but in much deeper regions—the amygdala, hippocampus, hypothalamus, brain

stem—that are only marginally affected by thinking and cognition. These studies showed that people process their trauma from the bottom up—body to mind—not the top down. If trauma is situated in these subcortical areas, then to do effective therapy, therapists need to do things that change the way people regulate these core functions, which probably can not be done by words and language alone. Van der Kolk stressed that much of the work of healing from trauma is "really about rearranging your relationship to your physical self. If you really want to help a traumatized person, you have to work with core physiological states and, then, the mind will start changing" (Wylie, 2004, p. 40).

This understanding and the strong desire to provide a more effective way to more fully relieve John's suffering led me to explore a deeper knowledge of the central role of fixed physiological and sensorimotor patterns in many trauma survivors and possible ways to weave aspects of sensorimotor psychotherapy (Ogden & Minton, 2000; Ogden, Minton et al., 2006; Ogden, Pain et al., 2006) into my foundational response to dissociation through relational trauma psychotherapy (discussed earlier in this article). Ogden, Pain et al. (2006) summarized sensorimotor treatment as follows:

> Sensorimotor treatment focuses on the re-activation of autonomic hyper or hypoarousal and defensive action tendencies as these occur within the therapy hour. In a bottom-up approach, the narrative becomes a vehicle for activating these physiologic responses and movements so that they can be studied and ultimately transformed. The therapist and client have an opportunity to work with the implicit elements of traumatic memories by directing the client's awareness away from the verbal components of memory to the nonverbal residue of the trauma. Somatic bottom-up interventions that address the repetitive, unbidden, physical sensations of hyperarousal and hypoarousal together with movement inhibitions can then be integrated with more traditional top-down interventions that help to transform the narrative of the trauma and facilitate the development of a reorganized somatic sense of self. The sense of self is represented not only in beliefs and emotional responses but also in physical organization, postural habits, and movements of the body. (p. 273)

A much more in-depth understanding of the theory and practice of the sensorimotor approach to psychotherapy is necessary than can be provided within the context of this article. This can be found in the pioneering work by Ogden, Minton et al. (2006), *Trauma and the Body: A Sensorimotor Approach to Psychotherapy*.

The following excerpt from a session with John (about 2 years into therapy) demonstrates the impact of the introduction of this process within our trauma psychotherapy. Specifically, from a sensorimotor perspective this session focused mainly on the recognition and development of "somatic resources for self soothing" (Ogden, Minton et al., 2006, p. 230) to create a safe framework for becoming aware of the body. For John, his relationship

with Star had grown to bring a great deal of soothing and an opportunity to build on that physical awareness through an external source.

John: I still can't believe you are letting Star come here. I told her you're a nice person so she should be okay. *[As John took his cat out of the carrier, his body seemed to soften and he gently held her in his lap.]*

Therapist: Well, thanks for that compliment, John. She's beautiful . . . just like you described. And she really seems to like sitting in your lap.

John: Yeah, she's pretty good at always getting my attention.

Therapist: What are you aware of in your body as you notice Star sitting in your lap?

John: I don't really know what you mean, but I know she's getting heavier—I may have to stop giving her so many treats.

Therapist: How do you know she's getting heavier, John—can you feel her weight on your lap?

John: Yeah, I guess so. *[As John answered, his voice trailed off and he seemed to be disconnecting from our conversation while gently rubbing his hand across Star's back.]*

Therapist: John, it seems like something about this is upsetting you. I wonder if we can stop our discussion for just a moment and maybe we could show Star the office.

[I stood up and motioned for John to join me. We walked around the office together, John holding Star, and talked about the many things that Star might experience as toys if we were to let her run free. I handed John different items, encouraging both tactile and verbal connection.]

John: I'm okay to sit back down now, but I don't think we should talk about the lap anymore today.

Although an initial step toward the acknowledgement of John's physical experiencing of self-soothing through his relationship with Star, this session also demonstrates the complexity and crucial importance of pacing the sensorimotor experience and remaining attuned to the client's nonverbal cues much in the same way as in more traditional relational trauma psychotherapy. John and I continued to revisit this session over time with a curiosity and attention to his body's need to physically experience his torso and chest muscles being open and "unguarded" from the danger of being stabbed. Initially, I modeled this physical movement for John and subsequently we practiced the movement together until one session his body sat up with remarkable grace, his chest muscles opened wide, and John described a sense of freedom and relief. He was eventually able to stay grounded and present with the physical sensations in his lap, chest, and hands while petting Star and to utilize his positive internal experience of these sensations for self-soothing. We also continued to build on John's realization that walking and focusing on objects in the room were very useful in reducing the familiar pull toward disconnecting or dissociating from the current moment.

PHYSICALLY CARING FOR THE DISSOCIATED BODY

While we are growing in our understanding of the intrapsychic, the neurobiological and sensorimotor processes connected to dissociation, the experience of "that part of the body is just gone," present an enormous challenge in supporting clients to physically care for their bodies. This dilemma calls upon practitioners of all models of psychotherapy, along with providers of physical medical care, to educate ourselves to recognize the potential "cues" that clients may be disconnected from their physical bodily experience in ways that may have a negative and even progressive impact on the integrity and well-being of their bodies. In other words, we must not actively participate in the intrapsychic function of dissociation that represents *the need not to know*.

In addition to educating ourselves, we must recognize that noticing and naming what is being left out is just as important a premise within relational trauma psychotherapy as noticing and naming interpersonal processes and reenactments that are occurring in the therapy relationship. This implies that therapists take an active role in trying to remain aware of and understand with clients the origins and meanings of clients' self-protective psychological processes, including dissociation. At the same time, therapists must also acknowledge and discuss with clients any actual physical consequences that may have resulted from clients' traumas (Haven & Pearlman, 2004). This concept of noticing and naming what is being left out certainly applies also to other providers who are working with dissociative clients, such as physicians, case managers, bodyworkers, and so on. Unfortunately, many survivors have had traumatic encounters with physical health care providers as adults and may be quite fearful or unwilling to place themselves in an uncertain medical situation. This may necessitate that psychotherapists consider a more active role both in assisting a client to obtain a trauma-informed health care provider and in collaborating with that provider as needed throughout the client's treatment. Additionally, because the psychotherapist is often the only person with whom many clients have disclosed the depth of their traumas, it is a central role of the therapist to provide education and assistance regarding the growing options for collaborative and adjunctive care (such as craniosacral therapy, acupuncture, yoga, massage, integrative medicine, etc.).

As noted earlier, Schnurr and Green's (2004) model depicts the association of traumatic events and poor physical health through psychological, biological, attentional, and behavioral mechanisms and stresses the importance of an integrated approach to care. The authors appropriately stressed that these mechanisms "interact to strain the body's ability to adapt, thereby increasing the likelihood of disease and illness behavior" (p. 268), and they have drawn specific implications for primary care and mental health practitioners, policymakers, and researchers in this arena.

John struggled over several years to effectively care for his physical body. Many things contributed to this struggle: a lack of understanding and

education about the specific needs of his body, lack of regular medical checkups or care, continued smoking, lack of financial resources or adequate medical insurance, lack of exercise, chronic hypoarousal, disconnection from physical pain cues due to dissociation and self-generated analgesia (Haven, 2002; Haven & Pearlman, 2004; Nijenhuis, Vanderlinden et al., 1998; Van der Kolk, 1994), lack of collaborated care among providers, and, yes, a psychotherapist who at some points had to learn along with him about some of the complexities of dissociative experiences, both psychological and physical. Over time, all of these complexities resulted in a medical crisis for John that required an extensive biopsy of his lung—an intrusive procedure on the "part of the body that was just gone." Thankfully, as this possibility became imminent, John, his primary care physician, the specialist who would perform the procedure, and I were able to develop a collaborative process and plan that took into consideration John's particular dissociative coping strategies, his past trauma, and potential emotional and physical triggers and that included my being present with John both before and shortly after the procedure. (This collaboration was possible in large part due to the diligent attention John and I had paid over the years to the complicated process of building a relationship with a primary physician who was compassionate and educated about the impact of trauma.) The following is an excerpt from our discussion about an hour after the procedure while John was still in the recovery room:

John: Well, I guess they cut out whatever they had to and I'm still alive. *[John's facial expression was a slight smile coupled with a sort of grimace that I understood to reflect physical pain.]*

Therapist: You sure are . . . you know, if I'm not mistaken you look like you're both smiling and hurting . . . is that right?

John: *[Looking down at his chest, putting his hand directly over the area of the incision]* They may have taken out part of my chest, but for the first time in a long time, I feel like this part of my body is back . . . I never thought feeling pain could be such a good thing.

CONCLUSION

Empathic engagement and the intimacy of the psychotherapy process with trauma survivors brings a sense of deep respect for the dissociative adaptation that many clients learn as a primary way to tolerate the impact of the suffering and terror they have endured. As therapists we just as deeply understand the ways in which dissociation no longer serves clients well as they strive to heal both psychologically and physically. Not feeling the pain may provide a safe haven from the immediate overwhelming circumstance, but it does not repair the damage or untangle the untold stories held within the body.

My hope in writing this article is to encourage us as psychotherapists to deepen our awareness and overall treatment orientation to include the body as well as the mind and to challenge ourselves to engage with our clients' embodied experiences. It is not enough, and is actually misguided, to focus exclusively on the cognitive and emotional meaning of the experience, the narrative, as the sole entry point to healing. We must understand and act on the reality that past traumatic experiences are indeed imprinted in the deeper regions of the brain that are only marginally affected by thinking and emotion (Van der Kolk, 2006) and are embodied in current physiological states and sensations of hyperarousal and hypoarousal together with movements (or lack of movement) and tissue memories within the body. It is crucial that we assist our clients in giving the body a voice, a visibility; or, as John said, we need to "bring back the part of the body that was gone." The integration of the mind and the body offers the greatest potential for resolving the suffering and long-lasting consequences of trauma and for restoring the innate capacity and desire to move toward health and healing.

NOTE

1. The identity of the client discussed in this article has been disguised by omission and alteration of non-crucial information. I express my sincere gratitude for the client's consent for use within the article of the material that is specific to his or her experience.

REFERENCES

Allen, J. G. (2001). *Traumatic relationships and serious mental disorders*. West Sussex, England: Wiley.

Davies, J. M., & Frawley, M. G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York: Basic Books.

DePrince, A. P., & Freyd, J. J. (2007). Trauma-induced dissociation. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 135–150). New York: Guilford Press.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*, 245–258.

Foa, E. B., Zinbarg, R., & Rothbaum, B. O. (1992). Uncontrollability and unpredictability in post-traumatic stress disorder: An animal model. *Psychological Bulletin*, *112*, 218–238.

Goodwin, J. M., & Attias, R. (1999). *Splintered reflections: Images of the body in trauma*. New York: Basic Books.

Haven, T. (2002, November). Physical health and dissociation in relational trauma psychotherapies. In L. A. Pearlman (Chair), *Complex trauma and survivors'*

bodies. Symposium conducted at the annual meeting of the International Society for Traumatic Stress Studies, Baltimore, MD.

Haven, T., & Pearlman, L. A. (2004). Minding the body: The intersection of dissociation and physical health in relational trauma psychotherapy. In K. A. Kendall Tackett (Ed.), *Health consequences of abuse in the family: A clinical guide for evidence-based practice* (pp. 215–232). Washington, DC: American Psychological Association.

Levine, P. A. (1997). *Waking the tiger: Healing trauma*. Berkeley, CA: North Atlantic Books.

McCann, I. L., & Pearlman, L. A. (1990). *Psychological trauma and the adult survivor: Theory, therapy, and transformation*. New York: Brunner/Mazel.

Misslin, R. (2003). The defense system of fear: Behavior and neurocircuitry. *Neurophysiologie Clinique*, *33*(2), 55–66.

Nijenhuis, E. R. S., Spinhoven, P., Vanderlinden, J., van Dyck, R., & van der Hart, O. (1998). Somatoform dissociative symptoms as related to animal defensive reactions to predatory imminence and injury. *Journal of Abnormal Psychology*, *107*, 63–73.

Nijenhuis, E. R. S., Vanderlinden, J., & Spinhoven, P. (1998). Animal defensive reactions as a model for trauma-induced dissociative reactions. *Journal of Traumatic Stress*, *11*, 243–260.

Ogden, P., & Minton, K. (2000). Sensorimotor psychotherapy: One method for processing traumatic memory. *Traumatology*, *6*, 149–173.

Ogden, P., Minton, K., & Pain, C. (2006). *Trauma and the body: A sensorimotor approach to psychotherapy*. New York: Norton.

Ogden, P., Pain, C., & Fisher, J. (2006). A sensorimotor approach to the treatment of trauma and dissociation. *Psychiatric Clinics of North America*, *29*, 263–279.

Pearlman, L. A. (1998). Trauma and the self: A theoretical and clinical perspective. *Journal of Emotional Abuse*, *1*, 7–25.

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: Norton.

Perry, B. D., Pollard, R. A., Blakley, T. L., Baker, W. L., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and use-dependent development of the brain: How states become traits. *Infant Mental Health Journal*, *16*, 271–289.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York: Norton.

Saakvitne, K. W., Gamble, S. G., Pearlman, L. A., & Lev, B. T. (2000). *Risking connection: A training curriculum for working with survivors of childhood abuse*. Lutherville, MD: Sidran Press.

Scaer, R. C. (2001). *The body bears the burden: Trauma, dissociation, and disease*. New York: The Haworth Medical Press.

Scaer, R. C. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York: Norton.

Scaer, R. C. (2007). *The body bears the burden: Trauma, dissociation, and disease. Second Edition*. New York: The Haworth Medical Press.

Schnurr, P. P., & Green, B. L. (2004). Understanding relationships among trauma, post-traumatic stress disorder, and health outcomes. In P. P. Schnurr & B. L. Green

(Eds.), *Trauma and health: Physical health consequences of exposure to extreme stress* (pp. 247–275). Washington, DC: American Psychological Association.

Van der Kolk, B. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry*, *1*, 253–265.

Van der Kolk, B. (2006). Clinical implications of neuroscience research in PTSD. *Annals of the New York Academy of Sciences*, *1071*(1), 227–293(17).

Wylie, M. S. (2004). The limits of talk: Bessel van der Kolk wants to transform the treatment of trauma. *Psychotherapy Networker*, *28*(1), 30–41, 67.