

Trauma Reveals the Roots of Resilience

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After September 11, a friend sent me the following quote from Hemingway, a gift I want to share it with you.

"The world breaks everyone and afterward some are strong at the broken places." I cannot think of a better way to capture what our aim is than to say that through our work, we try to help our patients – and ourselves-- become stronger at the broken places. In the process of doing the work, we also sometimes discover amazing places that have always been strong and were never broken. Not so infrequently, in the course of dealing with tragedy, with destruction, with misfortune, and evil, we are taken aback by the miracles that we are privileged to witness. Steeled for the worst, we encounter the best. It is not only that some are strong at the broken places; it is also that, through trauma, others become strong, and discover they're strong in ways they never knew. For sometimes trauma awakens extraordinary capacities that otherwise would lie dormant, unknown and untapped. Without the trauma, they would never see the light of day.

Crisis is opportunity. In the early 1940s, hundreds of people died in a huge fire at the Coconut Grove Hotel in Boston. After seeing hundreds of patients, survivors and people who had lost people, Eric Lindemann (1944) wrote an article about the symptomatology of acute grief. In it, he articulated the principle that crisis creates psychic fluidity and thus an unequalled opportunity for change. Crisis loosens defenses: fluidity can be found where previously rigidly entrenched patterns prevailed. So compelling was his discovery, that the creation of an *intrapsychic crisis* became the goal of an entire therapeutic modality, the experiential STDPs (short-term dynamic psychotherapies), the psychotherapeutic tradition that informs my work (cf., Davanloo, 1990; Fosha, 2000b; McCullough Vaillant, 1997).

Thus trauma is a transformational opportunity. Michael Eigen, a New York psychoanalyst, referring to the aftermath of the World Trade Center attack, recently said: "the economic spirit dominates our age. When a great economic signifier explodes and collapses, a hole is created for something more, something else to happen. That is why so many of us cringe when we are told to go spend money in the face of death. As if money, anymore than words, can fill the gap, as if money is spiritual sustenance. ... I think that what many of us are fighting for is that a moment of transformation not be missed. There is danger that trauma be trivialized, commercialized, politicized" (Eigen, 2002).

I think that is precisely right: *What many of us are fighting for is that a moment of transformation not be missed.* In the immediate wake of September 11, horror co-habitated with heroism. One of its body parts destroyed and smoldering, the city was alive as never before. People were heroic, awake, generous. Strangers made contact. Extraordinary kindness was the rule. Now, only a few months later, the greatest danger is the numbing, the forgetting, the deadening, the return to cynical business as usual. For it is in dissociation that the seeds of traumatic repetition are sown. The enemy of healing is not only trauma; the even more subversive enemy of healing is detachment, trivialization, stagnation,

and the loss of feeling and meaning.

Inspired by these experiences, I offer a few reflections.

Trauma Transforms. Trauma transforms. Certainly for bad, but also for good. And it is precisely that huge transformational potential that we want to harness for our own aims. We want to harness that massive energy and channel it in a positive direction. We are guerilla warriors, subversives in the war on trauma. In treatment, we seek to co-opt trauma and use its energy to transform both trauma and the self, and to promote well-being.

You Don't Have To Feel Bad Before You Can Feel Good. Feeling good does not have to only come after we've done our time feeling bad. In therapy, the patient doesn't first have to have deal with feeling bad for a whole long time before he or she can feel good. Feeling bad and feeling good need not be sequential. They are parallel processes, which often intersect and intertwine, and relate to one another in all sorts of different dynamic ways. Therapy **is** about dealing with the bad. But therapy also needs to be about engaging and accessing the positive. The two go on side by side, not first one, and only then, the other .

Maurice Sendak, the great illustrator of children's stories, did an animated version of Hansel and Gretel for television. When asked "Why Hansel and Gretel?," he replied: "What drew me to the story and what I wanted to show people, is that even in the midst of trauma, children play." In the midst of trauma, and its sequelae, children play. And amidst the devastation of trauma, people laugh at jokes, write divine music, make love, help friends who are hurting, enjoy the beauty of a sunset. Those moments are essential: they reveal capacities for living and resources that are extraordinary allies in treatment. They are the volunteer cadres of the psyche, waiting to be called to report to duty. We must call on them.

Paradox in the Treatment of Trauma: The seeds of healing are in what we fear the most; illness is rooted in trauma-forged attempts at safety. People who have been overwhelmed by unbearable emotions become afraid to feel, and develop affect phobias. They seek safety in numbing their senses, steeling their bodies, and hardening their hearts. People who have been hurt, betrayed, and discarded by others they have loved, become afraid of loving. Afraid of emotional contact, they seek safety in isolation, detachment, and a relentless, and brittle, self-reliance. In thus seeking safety, they actually cut themselves off from the two greatest sources of adaptation Mother Nature endowed us with. Emotions and attachments (Bowlby, 1988; Darwin, 1872). The defense mechanisms instituted to protect instead lead not only to emptiness, loneliness, fragmentation and despair, but also to being out of control and to being either a target for further victimization, or else at risk for becoming a victimizer. The goal of therapy is simple: restore the capacity to feel and relate, so that these natural affective change processes --attachment and emotion-- have a chance to serve the individual's optimal adaptation (Fosha, 2002a). In order to help patients relate and feel and deal, we must also help them develop safety procedures that do not defensively abort the very forces that can promote healing.

A DETOUR: A Case Vignette: Ellie

I want to tell you a story, that focus on the importance of therapeutic affirmation. The patient, I'll call her Ellie, is a woman in her 50s who has been through more than she cares to remember. But, unlike others, she remembers. At age 5 her father died, and a series of incidents of abuse, neglect and deprivation followed. In the last 10 years, she lost a breast, she lost a husband, and as of September 11, her job lies beneath what was the North Tower.

But this day, her mind is on an incident that took place more than four decades ago. In the telling, it is as vivid as if it had happened yesterday. An eighth grader with a active imagination, she decided to relieve her depression by having an adventure. Like Toad in *The Wind in the Willows*, she decided to escape from her prison, i.e., her room, by climbing out the window. She fashioned a rope out of rags, she tied them together, she threw the rope out the third story window of the family house (she did not want to tear the sheets on her bed to shreds and get into even more trouble). She climbed out her window and started to shimmy down the improvised rope. There she was, hanging out her window, when the rope of rags broke. She was hanging by a thread. Literally. She screamed for help, she screamed for her mother. No one came. As in a grim Hans Christian Andersen tale, she could hear the rest of the family laughing and talking on the ground floor, the noise of laughter and talk and silverware clinking against plates mixing with her screams for help. It became apparent to her that no one would come and rescue her. She thought she was going to die. She remembers rapidly trying to figure out the best way to fall so as to maximize her chances of survival and determined that it would be best if she jumped. Jump she did: she broke her arm but she did survive, as she just barely avoided rolling off the roof.

As I was listening to her, echoing in my mind was a phrase from Ferenczi, an Eastern European analyst aeons ahead of his times in terms of his understanding *of*, and innovative work *with*, trauma. He said (I looked up the quote after the session): Sometimes, we encounter "the sudden, surprising rise of new faculties after a trauma, like a miracle that occurs upon the wave of a magic wand, or like that of the fakirs who are said to raise from a tiny seed, before our very eyes, a plant, leaves, and flowers. *Great need, and more especially mortal anxiety, seem to possess the power to waken up suddenly and to put into operation latent dispositions.*" (Ferenczi, 1933, emphasis, added). Ellie's capacity to both feel the fear (and not numb out or dissociate) and let the fear be an organizing emotion, kicking into gear her adaptive capacities for a successful escape was stunning to me. I decided to share with the her what had come into my mind and what I was feeling. I told her what Ferenczi said, I told her how taken I was with her, and I told her how remarkable I thought she was to be able to mobilize her resources and attend to herself so competently and creatively in the face of mortal anxiety. The patient started sobbing and had a major breakthrough.

For Ellie, the trauma had not been that she almost lost her life. The trauma was that she was abandoned, that she was dismissed, that she was ridiculed for her fear and her need, and that she was made to feel that she was bad and unworthy of care and responsiveness and protection. The sequelae of *that* trauma were reflected in a self that she felt was unworthy of good things, especially care. And like many trauma survivors, she invariably ended in traumatizing situations (Levine, 1997; van der Kolk, 2001), where she was forsaken by the very people supposed to care for her, in her case, her oncologists and mentors and supervisors.

Never affirmed for her courage, she had only been chastised for her stupidity. Most painful to her was

not that she had been on the ledge of death. (That seems to have gotten processed). Most painful to her was how ashamed she had been of herself in response to her family's ridicule and dismissal; buried even more deeply was the devastating feeling of being abandoned to die by their indifference: she had learned that in fact the family had heard her screams, but had dismissed them as "Ah, there goes Ellie having a temper tantrum again." Instead of the shame and self-contempt she was used to feeling, my comment released an enormous untapped grief and triggered the first waves of compassion for herself and empathy for what she had gone through.

Several themes here are worth noting: the little girl's resourcefulness in the face of mortal anxiety; the clinical strategy of affirmation; the impact of using the therapist's authentic experience; the therapeutic combination of affirmation and personal engagement getting the breakthrough; the nature of the breakthrough being a powerful emotion, in this case, grief and pain for the self; and finally, the endlessly surprising idiosyncrasy and specificity of human experience. The most painful part for the patient was not that she had almost died but rather that she had been humiliated by her family who had failed to respond to her in the first place. It is important to listen to the self. Which leads me to the next set of reflections.

The Triumph of the Self Reflected in the Idiosyncrasy of Personal Experience vs. the Intrapsychic Transmission of Trauma: The Telling Detail Matters. What is most traumatic to the individual –what the individual is least able to process—is not necessarily what is most scary, or most normatively horrible, or what threatens human life the most. Often, what is most traumatic involves some extraordinary betrayal, assault, betrayal, of who we know ourselves to be. What is often most traumatic –and also, what ends up containing the map to healing within it -- is a detail of self experience. A patient who was raped as she was coming out of the shower said that what bothered her the most was "that I was skinny and naked and he was dressed and big" (van der Kolk, 2001). It is not that his mother beat him savagely that pains my patient Tim the most. Most wrenching for him is an incident that occurred at age 5: There was a fire in their building and everyone was rushing down the stairs. his mother did not grab his hand, instead, she grabbed the hand of his younger cousin Gloria, leaving him to follow behind of his own accord.

The telling detail is crucial. It is where the individual meets indifferent fate, and marks it with the stamp of personal experience, anyway. In how we experience what happens to us, we make it our own, thus fighting against the obliteration of the self. Experience is an activity: The first step in the recovery from trauma and the turning of passive into active is already there. Against all odds, our subjectivity makes its mark on overwhelming forces by virtue of how we experience them. It is the imposition of meaning on meaninglessness. The telling detail reveals the humanity of the person that trauma threatens to wipe out. A deceptively simple question can unlock access to the self: "what represents the worst part of the incident for *you*?" So often, the answer is so surprising. A small gesture of human kindness, a moment of meaningful contact or secret subversion, or an act by which the self can assert its impact, these can make the difference between PTSD and existential anguish, rage, pain and sorrow.

Intrapsychic Transmission. The other side of the coin is how the trauma has its way with the self. Much has been written on the intergenerational transmission of trauma (e.g., Fonagy et al., 1995; Main, 1995; Schore, 1996; Siegel, 1999). But the psychological experience of trauma also involves the intrapsychic transmission of trauma from environment to self, from external event into internal experience. This is the insidious process by which the individual treats herself as her abusers (or external events) treated her, as revealed in symptoms of PTSD and characterologic patterns of self-

sabotage. Pathology results when what happens on the outside comes to live inside the individual and it is the individual who is the source of her own torture, abuse, dismissal and neglect. Metabolizing the pain of facing how, internally, the self has joined the abusers, in the traumatization, abandonment, torture and dismissal of the self is one of the many challenges in the treatment of the sequelae of trauma.

In affirming the healthy self, the courageous self, the resourceful self – and making sure the patient is able to take in the affirmation—we promote the patient’s self esteem and sense of being worthy. It is only with an active sense of deserving to be treated well that the intrapsychic transmission of trauma—the insidious process by which the individual treats herself as her abusers had—can begin to be reversed. The reversal begins with small genuine acts of affirmation, as my spontaneous response to Ellie. I will use this as an example of the need to affirm the survival in the midst of the destruction. The focus on is on the self’s generativity, resourcefulness, creativity and self-care which is already contained in the trauma response, or more accurately stated, in the response of the self to traumatizing conditions and situations.

The trauma of almost losing her life and of ending up in a cast for months, the fear that had to be conquered in order to jump was not what was traumatic for Ellie. What was traumatic for Ellie was her family’s literal dismissal of her cries for help. In order to preserve the attachment bond --for after all, hanging on to life by a thread of rope, she had had more than enough of a taste of how stark aloneness was-- she joined her family: In an implicit exoneration of them, and an abandonment of her own self, she began to see herself as contemptible, ridiculous, unworthy.

In certain ways, Ellie had sold her creative resourceful self down the river, so that she could continue a connection with her family. That was the self that needed to be noticed. What needed to be validated and reclaimed in the therapeutic setting was the self’s experience that Ellie had excluded, dismissed and sacrificed so as to be in connection with her family. My validation of her courage and resourcefulness got her back in touch with those aspects of the self, which were not destroyed but were dissociated. The validation also implicitly and procedurally signaled a relationship, the therapeutic relationship, where emotional connection did not require the exclusion of vital aspects of the self.

On Vulnerability and Surrender: The Uncomfortable Similarity between Trauma and Therapy. (Inspired by the EMDR (Shapiro, 1995) prompt “Let whatever happens, happen”)

The essence of trauma is helplessness: the self is helpless in the face of an onslaught of events, helpless to alter the course of what happens. The self is helpless in affecting the course of events: whatever happens is going to happen. In trauma, we are helpless in the face of a whirlwind of damage and pain. Trauma compromises the capacity to trust, to be vulnerable and to surrender to experience.

Paradoxically, the therapeutic situation, when it is at its most powerful, uncomfortably shares essential elements with the trauma situation (though, needless to say, also with crucial differences). It requires vulnerability and surrender: the vulnerability to trust and to be open and to allow another, *the therapist*, and a process, *the therapy*, to have an impact; and the surrender to one’s inner experience, to letting something of uncertain ending, take one over. It requires surrender to processes not ruled by logic and reality, but rather ruled by the logic of biological and psychological survival, processes mediated not by the neo- cortex, but subcortically and by the right hemisphere. As Peter Levine (2002) said, “These processes have a reason that reason cannot reason.”

The issue of control and surrender is a particularly tricky one in trauma. Defenses in essence represent the patient's attempts to exert control on a world that has become a scary and evil. Though informed by the best of adaptive strivings, in the long run, defensive strategies produce a very mixed picture, where the bad news side of it is pretty bad.

A very striking aspect of EMDR --which is at the essence of experiential work in many different modalities-- is the surrender of will. Once conditions of safety obtain, and the patient accepts and goes with the basic protocol something of great therapeutic significance has occurred. The capacity to surrender, implying trust, is already in operation the moment the patient accepts the basic instructions: "let whatever happens, happen,". Before anything EMDRish has happened, there has already been a profound experience: traumatized patients who, *for good reason*, are notorious for resisting letting go, are letting go and abandoning themselves to the process. The patient has agreed to let happen something that he or she is *not* in control of.

In general, the bottom-up processing of experiential approaches differs from top-down approaches: the "I" is not in the driver's seat and is asked to take the seat of observer, of narrator. We do want the orbito-frontal cortex involved, we do want the reflective self function to operate, but what we want to narrate and reflect on ultimately is the *completion* of affective change processes with, so to speak, a mind of their own (Fosha, 2002a, 2002b). The "I" only emerges strengthened. When conditions of security have been established, with safety and mindfulness and sincerity operating dyadically in the service of healing, then bodies can surrender to our emotion and minds can open to the impact of attuned, mindful others.

It Is Just as Important to Process the Experience of Healing and Being Helped as It Is to Process the Experience of Trauma and Being Hurt. Getting the breakthrough, getting the corrective experience, having the reparation, getting to the other side of the trauma response is crucial and necessary, but sometimes it is not enough. Having the experience is the first step of healing; but **registering** that the experience has been had and that the interpersonal environment in which it took place is devoted to, and welcoming of, the authenticity of the individual's experience is the second, and sometime more tricky, part of the work. It is there that the more pernicious and subversive aspects of trauma exist and contaminate the self.

The capacity to abandon oneself to the ministrations of the other is the essence of being taken care of. But in order to reverse the effects of trauma it is not sufficient that care be *given*. It must be *received*.

Healing has a phenomenology, biology and psychology all its own (Gendlin, 1981; James, 1902; Levine, 1997), something I have written about (Fosha, 2000a, 2002a, 2002b). It is as important to explore, in experiential detail and with great thoroughness, healing therapeutic experiences, as it is to explore traumatic processes. We do not want to only focus on the experience that must be undone and transcended, that is, the trauma. We must also focus, with equal devotion and discipline, on the experience of feeling relief and being helped. One of the greatest damages of trauma is that it instills in people, a suspicion of their own joy, openness, contact, and well-being. We have to help our patients tolerate and experience feeling good, feeling joyful, feeling loving, as well as to be able to benefit from receptive affective experiences, i.e., feeling seen and understood, feeling helped, and feeling loved.

The patient needs to process the experience of healing. In its every aspect, it is a triumph in the face of

trauma. The experience of healing is an act of reclaiming of the self, an act of trust, an act of acknowledging deep impact upon the self, though this time, benevolent impact, a moment of vulnerability and trust rewarded. Find the specific. Find the idiosyncrasy. Find the place and the moment where and when self and relatedness transcend –for good or bad—the indifference of fate. And once you have it, once you find it, process the meta-experience, that is, **the experience of the experience** with the patient.

In Conclusion. As therapists, it is important to not be intimidated. To be effective we must use heart and mind and body. Throughout the history of our field, everything good and potent has been co-opted, corrupted or calumniated, with good and bad intentions (e.g., Tomkins, 1981). That is no reason to give up and relinquish our deepest resources and tools of healing. Fear is the legacy of trauma. As healers, the courage to make use of our most effective tool, our full selves, is the profound gift we can offer our all our patients, but all the more so our trauma patients. In our work, we must not be afraid to love, to suffer, to think, to feel, in other words, to be alive. That is the best guarantee that moments of transformation will not be missed.

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