



Trauma, dissociation and somatization

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ABSTRACT

In this paper, a way of accounting the traumatic experience, its effects on the individual, and the ways to help its assimilation with special reference to somatization is described. A dynamic model that puts the traumatic experiences in relation with the subject, and the processes through which both the subject and the experience become what they are, is contrary to the current medical model organized on the basis of the nosological categories described in the DSM and ICD classifications. A model of development of the self-in-relation, which can account for the character and extension of the effect of experience through different systems of meaning is explained.

Key words: trauma, dissociation, conversion, somatization, therapy

INTRODUCTION

This paper is intended to provide a theoretical understanding, beyond reference to nosological entities which are usually used, of clinical interventions which we've been doing in persons who have been victims of traumatic experiences. It is assumed that nosological entities represent more of an epistemological obstacle for the understanding of the experience and its assimilation by the person who has lived it, than an useful instrument to guide therapeutic action.

In the last few decades there has been a resurgence of interest in dissociation as a fundamental mechanism for the understanding of human, individual and collective reactions to trauma. Recent publications about neurobiology have undoubtedly contributed to this increased interest.

In 1896, Freud (Laplanche & Pontalis, 1968) renounced to traumatic etiology as a frame for the understanding of conversion symptoms. He proposed an etiology for these symptoms based on the intrapsychic conflict in the presence of unacceptable impulses for the person. This change in thought influenced the decreased interest in research on the traumatic events in the childhood of patients, while therapists focused on the study of the phantasmatic world of the symptomatic subject.

The arrival of the DSM classification accentuated the existing separation between what is now considered dissociative disorders, versus disorders caused by stress or the so-called somatoform disorders. The new classifications did not help to establish lines of research connecting disorders classified in different nosological fields.

Somatization refers to the tendency to experience stress in the form of physical symptoms, bodily complaints and/or to experience oneself mainly in physical terms. The psychological and physical aspects of an experience are not integrated, and in this way somatization also involves an alteration of the perception of the *self*.

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The belief that somatization can be related both to trauma and to dissociation as a defence mechanism is not new. Janet (1920) hypothesized that memories of traumatic experiences, which are stored outside the field of conscience, may contribute to dissociation and somatization in the form of hysteria. Besides, Freud talked about the conversion mechanism (Rodin, Groot & Spivak, 1998).

Currently, the new developments from neurobiology help to give theoretical support to the hypothesis which highlights the close connection among trauma, dissociation and somatization.

And thus, in the current DSM IV, Van der Kolk *et al.* (1994; Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane and Herman, 1996) point out that dissociative symptoms are present in the diagnostic categories of Post Traumatic Stress Disorder (PTSD), Acute Stress Disorder, Somatization Disorder and Dissociative Disorders. Van der Kolk (1994) makes a strong case for the consideration of dissociation, somatization and affect dysregulation as late expressions of trauma even in the absence of continuing criteria for the diagnosis of PTSD. In doing so, he echoes Nemiah's concerns (1998), who notes that the diagnoses of PTSD, conversion disorder and dissociation are connected by the common process of dissociation itself, whereas their disparate placement in different categories of the DSM IV make difficult the investigation of the psychodynamics of trauma. (Scaer, 2001 a,b).

Connection between somatization, trauma and dissociation is supported by empirical data from literature (Rodin *et al.*, 1998) such as:

- The association among somatoform disorders (hypochondria, body dysmorphic disorder, pain, somatization, conversion) with a previous history of trauma and dissociative symptoms. Pribor, Yutzky, Dean *et cols.* (1993) found that 90% of women with somatization disorder reported a history of physical, emotional or sexual abuse and 80% of them reported some type of sexual abuse.

- Association between sexual trauma and functional somatic disorders.

- It has not been demonstrated that trauma or dissociation are related more frequently with somatoform disorders than with other psychiatric disorders.

- As regards eating disorders, a diminished emotional awareness (alexithymia) has been frequently reported. Association between dissociation and eating disorders. There is also an increased prevalence of diagnosis of multiple personality disorders. A high number of sexual abuse cases have also been reported (though for some authors, the history of sexual abuse in these individuals is not more common than in the general population).

- The different findings suggest that trauma and sexual abuse, rather than being related to a specific disorder, are non-specific risk markers of psychiatric morbidity.

- In factitious disorders it has been noted that the physical disease might be a way of concretizing and validating a subjective sense of suffering and the need for assistance. The simulation of the illness or the medical imposture may increase the sense of reality, since physical symptoms are experienced as more meaningful and real than is the emotional experience.

Dissociative mechanisms may contribute to the fabrication of the imposture.

All this data give empirical support to the possible association among trauma, dissociation, and somatization. It is possible that all of them are related because all are associated with or represent disturbances in the nature and processing of the emotional experience. The literature on dissociation usually and especially deals with the *big trauma*, but equally important seems to be the pre-morbid and subsequent capacity to experience, tolerate, and trust emotional experience, as well as the emotional availability of significant others to determine the effects of trauma.

The authors of this paper have reached to these topics from different clinical experiences: either from the assistance to victims of traumatic situations in catastrophes or from the treatment of patients with chronic pain or oncological diseases or from the clinical treatment of patients showing serious personality disorders. Our interest has been to focus on the exploration of dissociation as a mechanism common to all of them. Both somatization and dissociation reflect difficulties in the organization and integration of subjective experience.

Also in therapeutic stances it has frequently been observed that, traditional psychotherapeutic techniques, specially those based on the presumption that "*talking does cure*", were not sufficient neither for traumatic reactions nor for the somatization disorder in particular.

A comprehensive frame based on dissociation and a psychotherapeutic frame based on the integration of emotional experience into the subject's narrative, appears to be necessary. Psychotherapeutic treatments should be directed toward the emotional experience directly when "*merely talking, does not cure*" (Griffith & Griffith, 1996).

The idea that dissociative symptoms are related to traumatic experiences is nowadays generally accepted (Nemiah, 1998; Rodin *et al.*, 1998) and, in this paper, somatization will be regarded as a type of dissociative response to a traumatic situation.

1. TRAUMA AND IDENTITY

We start from the consideration that "trauma" is an experience that cannot be assumed with the usual cognitive and emotional schemes of a person. It is unassumable because the trauma questions the subject's relational world which is the same that the identity of the self-in-relation.

Human beings develop the sense of being one (*unique*), the sense of the self, through the construction of a unique narrative identity, that includes the idea of change and permanence. Without the experience of change, the person neither may have an active sense of the self in the future feeling the same person at the same time nor be recognized as a different person in the past. He may not even conceive a future where everything would remain immutable. Without the experience of permanence, the individuals may not be able to recognize themselves as the persons who were in the past, and may not be able to experience themselves as the same individuals projected into the future. Without the sense of being "*the other and the one*", at the same time, the present would consist of

isolated events without connection with the past or the future (Fernández-Liria and Rodríguez-Vega, 2001).

Edelman and Tononi (2002) point out that one of the properties that all states of mind share relates to integration or unity. The subject cannot divide a conscious state into a number of independent components. Another property which these authors point out has to do with informativity, in other words, with the extraordinary degree of differentiation which allows the organism to choose one among the possible multiple states of conscience in fractions of a second. The idea that "*unicity entails complexity*" or that "*the brain has to face overabundance (of information) without losing unicity or coherence*" is supported from a neurobiological perspective. The aspects that are common to all conscious experiences relate to privacy, unicity and coherence (Edelman and Tononi, 2002). William James asserted: "*The universal conscious act is not 'feelings and thoughts exist', but 'I think' and 'I feel'*".

Ricoeur (1991) has developed the concept of narrative identity as a proposal to solve the problem of personal identity. In Miró's words (at the press): "When the problem is to explain the sense of unicity and temporal continuity, then, narrative offers a model which makes possible to integrate diversity, instability and/or discontinuity in the permanence in time. The storytelling achieves the temporal and meaningful unity through the construction of the plot in which we can understand how A is changed into B" (page 107).

The event is what makes the plot to advance and, in this sense, is in agreement with the plot. However, the event also questions the previous argument, and could be in disagreement with the plot theretofore existing (Ricoeur, 1991). Incorporating the event requires giving meaning to it (Miró, at the press). In the dialectical process between agreement and disagreement, the self constructs the meaning of the event which is always within the frame of its inter-subjective experience.

Traumatic events are the ones that we are concerned in this paper, and not only discrete gross events, but also microscopic and repetitive emotional injury such those related to parental failures in attunement and responsiveness to the emotional demands and needs of the child. The lack of response of the parents may have effects on the child's capacity to organize affects and perceptions. Parental understanding and responsiveness to the child's emotional experience may be vital in the development of the child's capacity for affect integration.

During traumatic dissociation, a fragmentation of the experience occurs which directly defies the sense of unicity of the self and makes impossible the integration of the experience into a self narrative.

From a neurobiological perspective, the unity of conscious experience is closely related to the coherence of the perceived events. Rubin's figure, or the young woman/stepmother, are examples of how we cannot be conscious of two mutually incoherent scenes or objects at the same time because our conscious states are unified and are internally coherent so that a certain conscious state hinders the simultaneous presence of another incoherent state with the former (Edelman and Tononi, 2002). The need to construct a coherent scene from different elements can be observed in all levels

and modes of conscience. In other words, the limited capacity and the serial succession of conscious states are the price we have to pay for integration. Thanks to the unity of conscious experience, without solution of continuity, a person can recognize scenes with a meaning and make plans and take decisions. In fact, under neurological stress situations, as pointed out by Edelman and Tononi (op. cit.), and we indicate that also under emotional stress in a traumatic situation, conscience can be "bent", "shrunk" or even "divided", but what the conscience cannot bear is to break its coherence. Apparently, the tendency towards integration is so strong that, after a traumatic experience, what is left after fragmentation tends to merge into a new coherent whole, even at the expense of the non-perception of a vacuum. Edelman and Tononi (2002) say: "*the feeling of an absence is much less tolerable than the absence of a feeling*" (page 41).

Persons need to recombine their narrative, even at the expense of shrinking, reducing or dividing the narrative. The construction of the self-narrative develops within the framework of a relational dialectic process. From birth, the self-narrative develops in a joint and reciprocal construction with an attachment figure. The idea of attachment relationships as constructors and regulators of the identity comes from these points.

2. ATTACHMENT, MEMORY AND TRAUMA

The self is configured around the emotional connection/disconnection axis. Humphrey says (1995) "the most interesting thing always happens at the boundaries. Everything that is interesting in nature happens at the boundaries: the surface of the Earth, the membrane of a cell, the moment in which a catastrophe occurs, the beginning and end of a life. The pages of a book most difficult to write are the first and the last" (page 25).

Boundaries are the areas of separation or differentiation, but also of connection of the self with the others and with the world. Boundaries are configured around the relational experience. In these areas of connection take place the interchange of biological and emotional nutrition that are necessary to form the mind and the self-experience.

The attachment experience, in the area of connection and differentiation with the others and the world, is the main regulator of emotion. Human beings need the attachment relationships as a regulator of their emotional system for the harmonious development of the self (Bowlby, 1977; 1985; 1986; 1988; 1990 a,b; 1991).

Affect regulation implies tolerance, awareness, expression and control of the physiological, behavioural or emotional aspects of an affective experience. When affect is undercontrolled, externalization behaviors and being out of control may appear; when affect is hypercontrolled, the person can show more internalized or constrained behaviours. Affect regulation includes internal regulation (self-regulation) and external regulation (through the social regulation) and it implies a relational process which is co-constructed initially with the caregivers as part of the attachment process (Keiley, 2002).

The development of affective integration depends, at least partly, on the degree in which the

caregivers pay attention and respond to the subjective experience of the child. Caregivers, in optimal conditions, help the child to identify and verbalize the affects which are initially experienced mainly in somatic terms. Thus, the child learns to distinguish somatic experience from psychological experience, and begins to understand that intense and contradictory affects can come from the same *self* (from a single (unique) self). The progressive articulation of the experience of the self is articulated through the integration of affective experience into consciousness.

The attachment system, as a system that regulates emotion and a key factor for the construction of identity, is activated under stressing situations. The aim of this activation under stress conditions is to reduce the arousal state and to restore the sense of security (Bowlby, 1977; 1985; 1986; 1988; 1990 a,b; 1991).

The child learns, through the attachment process, strategies of affect regulation to maintain the caregiver's proximity in stressing situations.

However, whenever the affective states are not recognized by the caregiver or are perceived as threatening, they can be defensively removed from consciousness and/or experienced as not valid or as poorly differentiated.

The tendency to exclude or deny affective states inevitably interferes with the psychological development because affects are vital for the organization of the experience of the self and because the mutual sharing of affective states help to establish an internal emotional regulation (Stern, 1985).

When the child depends emotionally on a caregiver who is not available, perceptive, responsive or inconsistent, the child may develop an insecure or avoidant or disorganized attachment style. In these type of attachments the importance of the bonding relationship is minimized or the communication of anger or discomfort is blocked (Keiley, 2002).

Through the repeated interactions with the attachment figures, attachment patterns are being formed, and these patterns are "remembered" in the different modes of memory and will influence not only what the child remembers but also the way in which the mental representations develop. Though autobiographical memory of the child is explicit at around the age of three years old, the behaviour, emotion, perceptions, feelings and the models of the others are being formed through experiences that occur before this type of memory is available. The development of the autobiographical narrative is influenced by elements of implicit memory. (Bremner and Marmar, 1998; Bremner, Scott, Delaney, Southwick, Mason, Jonson, Innis, McCarthy and Charney, 1993; Bremner, Southwick, Brett, Fontana, Rosinheck and Charney, 1992; Siegel, 1999).

Failure to establish a reciprocity relationship between the child and his attachment figures may contribute to the tendency of the child to be emotionally unconscious or to expel from the consciousness certain emotional contents. This is the central characteristic of dissociation. It is possible that, in these situations, the dissociation operates as a mechanism that defends the individual from overwhelming unpleasant and poorly differentiated emotional experiences (Siegel, 1999).

Subjects who have lived experiences of affective deprivation or abuses during childhood can be

more vulnerable for the presentation of dissociative symptomatology because they have not been able to construct a secure perception of the *self o self- in relation*. Traumatic experiences also question the *self in relation to others and to the world*. Thus, the trauma would have the capacity of forming the personal identity at the same level as the attachment experiences in childhood.

That is to say, trauma in childhood or adult life is described as the experience or experiences which will directly menace the construction or the sense of the *self- in - relation*.

In this way the traumatic experience is described as a fragmented, isolated and frozen experience in time. Frequently, patients describe their experiences as isolated fragments, for example different sensorial perceptions (smell, a sparkle, pressure), which reappear with a feeling of immediacy and without flowing in time (flashbacks, reminiscences). These fragments leave the subject withdrawn and alone (there is no narrative language through which he connects with the others). Miró (in press) points out that in "symptomatic narrative, the self is not inside the plot as if there was nobody to collect the complaint".

Whenever the subject lives a traumatic experience which the self cannot integrate with his emotional and cognitive schema, dissociation appears as a coping mechanism which allows the subject to go on living with his previous schemes but at the expense of removing from the consciousness a painful part of the experience (Kolb, 1987; Van der Kolk, 1994).

However, being out of the subject's consciousness does not imply not having an influence in the subject's psychic life. In fact, the traumatic experience has a significant impact on different aspects of the self. One of them is the effect on memory. Trauma-based memory phenomena often involve declarative (explicit, semantic) memory in the form of variably accurate verbal and imaginal recall of the traumatic event. Declarative memory is the form of memory which relates facts and events. From the neurobiological point of view, it involves hippocampal and prefrontal cortical pathways and plays a very important role in conscious recall of trauma-related events. It is notoriously inaccurate and subject to decay. The other form of memory is procedural memory which relates to the acquisition of motor habits and abilities, to the development of emotional memories and associations and to the storage of conditioned sensorimotor responses (Scaer, 2001 a,b).

Authors such as Scaer (op.cit.) propose that atypical neurological signs and symptoms which characterize conversion constitute perceptive alterations based on previous traumas and represent the same split of the consciousness that produces the disorders of the perception of time, space, reality and the self which characterize dissociative symptoms. Thus, conversion may belong to the same spectrum of post-traumatic stress disorder phenomena and to other dissociative symptoms, such as analgesia/pain or paralysis/crisis.

3. SOMATIZATION AS AN EXPRESSION OF THE BODILY EXPERIENCE OF THE TRAUMA

The somatization concept is misleading (Scaer, 2001 a,b). In current classifications, both somatization symptoms and the so called conversive,

hysterical, psychological or psychosomatic symptoms within a somatic pathological context are included within the somatoform disorders.

Both somatization and dissociation may be associated with a tendency to feel overwhelmed by affective states that are intense and poorly differentiated. Somatic symptoms may represent an attempt to organize and concretize inner chaotic emotional states (Goodsitt, 1983) or to rely upon bodily experiences, which are regarded as more real or more authentic.

Somatization can be understood in the framework of mind-body paradigm. As stated in the title of an article written by Scaer (2001 b), *the body bears the burden* of an emotional experience which has not been adequately discharged, processed or integrated into a narrative. Therefore, to attempt understanding somatization is necessary to understand how the inner world operates and its connection with the external world. For Scaer (2001 a,b) the brain is the main organizer of such connection. According to this author, the brain is interposed between both worlds and its main task is to mediate between them. To understand how the subjective experience of somatization occurs, we should understand the mechanisms of regulation of the internal environment in relation to the external environment.

Scaer proposes a somatic definition of dissociation (2001 a,b). This author presents a model of impaired brain function precipitated by a traumatic event whose completion or resolution was aborted by lack of spontaneous resolution of a freezing/immobility response, a phenomenon closely allied to the clinical psychological state of dissociation. The freezing state is associated with a complex set of somatic pathologic events characterized by cyclical autonomic dysregulation, and a state of vagal dominance. The sympathetic dysregulation primarily involves vasoconstriction, with dystrophic and ischemic regional changes, specifically in regions of the body that have been subject to dissociation, due to their residual representation of sensory messages of threat that have been stored in procedural memory system. The experimental model of *kindling* would be the responsible of the self-perpetuation of this pathologic process, driven by internal cues derived from unresolved procedural memories of threat, and enhanced by endorphinergic mechanisms inherent to both the initial response to threat, and to subsequent freezing/inmovilization response. In this context, a variety of chronic diseases are postulated to represent late somatic expressions of traumatic stress (Toomey, Hernández, Gittelman and Hulka, 1993; Waylonis and Perkins, 1994). These diseases are different in their clinical expression, but have in common the instability autonomic, subtle vasoconstrictive/ischemic features, and usually pain.

After a single traumatic experience or a disorganized attachment experience, which equals the trauma functions, the process whereby a behavior is chosen may acquire special importance and may be more intensely driven by "cues" coming from procedural memory, which are therefore non-conscious and stored in the subject's somatic terrains.

Damasio (1996) proposes the hypothesis of the somatic marker as a method of the body to make quick decisions based on everything it knows. The

question is that the *body does not know everything it knows*, i.e., *not everything that knows, knows that it knows*. The choices of the body seek to make the person get closer to pleasure situations and keep the person away from dangerous or adverse stimuli. The traditional hypothesis based on the premise that human behaviour makes decisions and chooses behaviours based on the "elevated reason", leaving the emotional aspect out, seems impossible. In Damasio's words: "... *the cold strategy which Kant, amongst others, advocated, has to do more with the way in which patients with a prefrontal lesion make decisions than with the usual operation in normal people*" (op.cit., page 165).

Damasio refers to the somatic marker as a bodily feeling that probably fosters precision and efficiency in the decision-making process. It functions as an alarm which allows people to make a decision based on a lower number of alternatives and immediately reject danger or it serves as an incentive with pleasure stimulus. According to Damasio: "... *somatic markers are a special instance of feelings generated from secondary emotions. Those emotions and feelings have been connected, by learning, to predicted future outcomes of certain scenarios*" (op.cit., page 166).

Sometimes, somatic markers can function outside the consciousness and use an "as-if" loop. Thus, the thought or image associated to the event may trigger the same bodily somatic state. This mechanism opens a channel for the explanation of the somatization phenomenon.

Most markers were probably created in the brain during the educational period (through the attachment experience) and socialization process, but the learning process is continuous during the lifetime. Somatic markers connect certain events with a certain body state. "*The decisive element is the type of somatic state which occurs in a certain individual at a certain point of time of his history in a given situation*" (Damasio op. cit., page. 171).

If we talk about traumatic stimuli, the somatic marker would restore the painful body state and would function as an automatic memory of the negative consequences.

The most important neural area for the learning of somatic markers is the prefrontal cortex which receives signals coming from all sensorial areas, including the somatosensory cortexes in which the present and past body states are continuously represented. The prefrontal cortex receive signals from perceptions of the outer world, from thoughts about the outer world or from perceptions of our body. It also receives signals from several bioregulating systems of the human brain (brainstem, prosencephalon, amygdalae, anterior cingulum and hippocampus).

In addition, it is involved in the categorization of experiences, i.e., the categorizations of the unique contingencies of our vital experience. Prefrontal cortex send signals to the autonomous system and promote chemical responses associated with emotion. Thus, as pointed out by Damasio: "the upper floor and the basement are harmoniously joined" (op cit., 174).

In other words, we could make ours the following statement: "*The heart has reasons that reason ignores*".

4. IMPLICATIONS FOR THE TREATMENT OF SOMATIZATION

Some authors have intended, in a body language, to reflect the neurobiological implications of psychotherapeutic treatments referring to their aim as “*extending the sphere of influence of the frontal lobe*” (Solms and Turnbull, 2002).

The very few studies on functional image in the field of psychotherapy show that there is a change in the functional activity of the brain and that specific changes mainly take place in the prefrontal lobules (Solms and Turnbull, op.cit.). To review treatments used in situations of responses to trauma we recommend consulting Foa’s outstanding compilation (Keane and Friedman, 2003).

It seems logical that psychotherapeutic treatments also reflect on the neurobiological plane when they are successful and bring about or facilitate changes on the psychological and social planes.

However, this close connection has not been taken into account in the design of many of the psychotherapeutic programs, so therapies who seek to cure through “the words” have not often included conversation “with the body”. The body itself has only been taken into account to “*talk about it*” and not “*with it*”.

Therapies should include the conversation with the body and not to continue disregarding the part of the body experience of the traumatic experience.

Novel therapeutic techniques emerge, some of them little known such as those seeking cerebral brain regulation through neurofeedback and the autonomic regulation through the control of the heart rate variability (HRV, *Heart Regulation Variability*) which may have profound implications (Scaer, 2001 a,b). However, any of these techniques must be included in a broader treatment program.

In the recovery process of what Janet called a “*disease of the synthesis*”, traumatic memories need to be integrated, and belong to a unique state of mind (Van der Kolk, 1994; Van der Kolk *et al.*, 1996). This is true for the dissociative symptoms manifesting themselves as somatization and for the dissociative symptoms manifesting themselves as a fragmentation of the self-consciousness (derealization, depersonalization, identity disorders).

Many authors also indicate that treatments may be phase-oriented (Horowitz, 2003; Pérez Sales, 2004; Van der Kolk, 1994; Van der Kolk *et al.*, 1996).

Van der Kolk (1994; Van der Kolk *et al.*, 1996) points out the following phases:

1. Stabilization and reduction of symptoms.
2. Treatment of traumatic memories.
3. Reintegration and rehabilitation.

The goals of the psychotherapeutic treatment, as described by Horowitz (2003) would be:

1. Helping the person to recover emotional balance.
2. Processing the meaning of the traumatic event.
3. Restructuring the person’s identity and his relationships, including to recover a stable, coherent and valuable perception of the self.

Horowitz (op.cit.) differentiates denial symptoms: affective blunting and inhibited behaviour; from intrusive symptoms: hypervigilance, sleeping disorders and nightmares, exaggerated emotional and startle responses, intrusive imagery and thoughts.

We suggest that any therapeutic approach should be designed in phases and include, for the particular case, the evaluation of what type of symptoms are predominant: either those based on denial and inhibition or those based on hyperalertness, and reviviscence of the experience. This distinction may be the basis to include, within the broad therapeutic plan, more abreactive techniques or more supportive techniques, respectively.

The experience of freezing (immobility), which trauma entails, requires emotional discharge to complete the experience. However, in some cases, the patient’s fear is too intense so the therapist should be sure of having built, through the therapeutic alliance, a safe place where the person can return when the emotional storm is too strong.

Treatment must be centered on recovering self-regulation and reconstruction of the self. Therapy must seek to restore a sense of security and predictability. That’s why we should be cautious, so that no early emotional abreaction should occur causing the patient to become overwhelmed, before the restabilization capacity has not been established. A situation like this can have adverse results such as the retraumatization of the patient.

5. PHASES OF PSYCHOTHERAPY IN TRAUMATIC REACTIONS

As we have described elsewhere the development of the psychotherapeutic process in general, we refer the concerned reader to those previous papers (Fernández-Liria and Rodríguez-Vega, 2001). In the current paper we will only point out the most relevant aspects of each of the phases when we refer to the psychotherapeutic interventions in traumatic reactions. Though our more specific concern is somatization, working with this symptomatology must be integrated into a broadest psychotherapeutic intervention.

5.1 Initial Phases

The establishment of the therapeutic alliance may have to be put before any other typical exploratory task of this phase in the treatment of traumatic reactions.

If the therapeutic alliance is understood as an attachment relationship, the establishment of this relationship may have special characteristics in the case of victims of traumatic experiences. For example, it will be different in an adult who was sexually abused as a child for a long time, than in a person who suffered assault and robbery in the underground. In both cases there is a challenge to the experience of security, but the most probable is that in the first case the establishment of a working alliance will be more difficult from the beginning.

The therapeutic relationship will play in the situation of traumatic stress a fundamental role due to its reconstructive emotional experience dimension. The therapeutic relationship shall become a powerful tool in the affect regulation so that the person can live again (de novo) the experience of emotional alignment with another (the therapist) which can be receptive and respond to the person’s needs.

The initial phases end when therapist and patient are in a position to establish a contract which

includes the formulation of the problem that the patients brings to the therapy, the conditions of the setting within they will work, and the focus which the therapeutic work will deal with. For all that, the therapist involves with the patient in the construction of the "pattern-problem" that, in the case of traumatic experience, is more clearly delimited than in other therapeutic interventions.

5.2 Intermediate Phases. The construction of the "pattern-problem"

Though part of the work which is included within the intermediate phases has already begun in the initial phases, we prefer to describe the process within the intermediate phases because we believe that the work with the pattern is done preferably in this phase of therapy.

Knowing what happened implies: 1) To whom it happened. To what person or persons within a particular relational or social context, 2) What the traumatic event means to that/those person(s) and to the relational or cultural context, and 3) How the traumatic event and its consequences was coped with.

According to Guidano (1991), also cited by Miró (at the press), the key to enter the patient's personal meaning consists in delimiting well the interface between action (what he felt, the immediate experience) and the character (the explanation, the kind of person he felt he was).

A. The review of the traumatic event

The therapist should be alert to explore the three spheres: cognitive, emotional and behavioural when this task is undertaken. The subject thought, felt and acted in a certain way when "that" occurred. Intrusive thoughts, which may appear later, hide some conflictive emotions that arise at this moment. For example, a woman victim of abuse by her spouse lived an earthquake which killed her husband. She had wished this to happen. For a few moments, it crossed this woman's mind that her life would change if her husband died. After the catastrophe, the woman went into a very severe depression, during which she had this intrusive and obsessive thought: "I should have helped him".

The biographical individual and relational review seeks the following:

- To provide the person with a frame in which he can express and share emotions. Recognizing feelings is always a helping task more or less painful or more or less comforting, but doing it with somebody else helps to put the feelings in perspective, and may be more effective in producing an emotional relief.

- To facilitate the experience of acceptance and the validation as a victim. We have to seek one's and the other's acceptance which are closely connected.

- The telling of the traumatic event, along with the cognitive, emotional and behavioural experience of the person, could be the first step towards the facilitation of a true "re-view" in which events and one's and the others' reactions are seen with different eyes. When an experience is narrated, the person is placed in the narrator's place and gains in perspective as regards his role of protagonist during the traumatic act. When one gains in perspective, new elements are appreciated which had not been taken into account previously

because the person accepted a unique explanation of the facts.

The biographical review helps to:

- The recovery, or better, the evolution of the person's identity.

- The beginning of the exploration of meanings.

- The facilitation of "felt" life sequences.

- To explore the impact on the patient's relational world.

- To detect strengths and weaknesses to work on during our interventions in the intra and interpersonal.

B. The exploration of the family and social context in which the traumatic event occurred.

Professionals are significant aiding agents when stress is high, but they cannot replace the network of the patient's significant relationships, usually the family.

Interventions must take into account the family or relational level: encouraging the family to share the patient's feelings, memories and experiences, rather than avoiding them; to be available for the member who is most in need; to resume their functions so that the family grief should not cause more damage to the family network that at this moment should be available for emotional and practical support.

In disasters affecting a community, when the usual and natural social networks are destroyed, grief is a collective process and the aid system will have to provide the way of facilitating collective rituals to help that society in the elaboration of grief.

When the therapist and the patient have done the previous tasks, the formulation of a "pattern-problem" may be possible. The problem cannot be formulated as "An earthquake occurred" or "I suffered an assault" (these experiences are a misfortune).

After conversation in the initial phases and more elaborately in the intermediate phases, therapist and patient might be capable of building a speech, such as the one below exemplified and which contains the "pattern-problem":

"I, who had that life ... (conclusion of the biographical exploration), when it happened ... (traumatic event), ... (did, thought, behaved)... and, from then, ... (feel, think, act) ... So that ... (influence on the person and his significant context as regards thinking, feeling and acting)".

In the case of child victims, when the traumatic event occurs before a memory or an experience of past life is formed, the same sentence would have to be adapted :

"I, who should have had that life ... (conclusion of the biographical exploration), when it happened ... (traumatic event), ... (did, thought, behaved)... and, from then, ... (feel, think, act) ... So that ... (influence on the person and his significant context as regards thinking, feeling and acting)".

C. Key elements and special techniques:

The freezing response, which takes place after the trauma, generates psychobiological responses such as reviscences, intrusive memories, nightmares and others, which are to be tackled with specific techniques.

In general, as pointed out by Apellaniz in his excellent review (Pérez Sales, 2004), exposure seems to be a fundamental ingredient in any treatment. This author cites exposure techniques with response

prevention, flooding, inoculation, or trauma desensitization techniques.

More recently, emphasis has been put on the facilitation during the therapy of *felt emotional experiences* which the subject recovers during the therapeutic process and should be reconstruct and integrate into his self narrative (Rodin *et al.*, 1998).

This work becomes especially significant when somatization symptoms appear. In these cases the traditional interventions focused on interpretations have not been very useful.

Some authors highlight the need of focusing during sessions on specific fragments of emotional experience. Rodin *et al.* (1998) indicate that to focus on specific moments of the patient's experience seems more useful than to focus on the overall experience.

Special attention must be paid to *the feeling of the experience and the sense of reality* in patients who tend to somatize and to remain emotionally detached. Reducing the therapy to an intellectual exercise should be avoided. The best way to work with emotions is using a bodily experiential language. As therapists, we have to be trained in the use of a language that evokes emotions, a language that serves to all sensory channels of experience (sight, hearing, taste, smell, touch) and to the inner world perception channels (kinesthetic and proprioceptive information). We suggest that therapists' training programs should include exercises and techniques aimed at practising these abilities (Fernández-Liria and Rodríguez-Vega, 2002).

The progressive and repeated elaboration of the emotional experience can help patients to increase their capacity to experience themselves in psychological terms, to distinguish the physical aspects from the emotional aspects of the experiences and to tolerate and integrate emotional states.

Techniques such as hypnosis and EMDR (*Eye Movement Desensitization and Reprocessing*) pursue the emotional and cognitive integration of the experience. The techniques are more thoroughly described elsewhere (Ironson, Freund, Strauss and Williams, 2002; Manfield, 1998; Maxfield, 1999; Pérez Sales, 2004; Shapiro, 2001; 2002), but we would like to highlight that these techniques can be easily integrated into the global therapeutic process herein described.

In Shapiro's words (2002), EMDR or adaptative information-processing model provides the clinician with a procedure to identify the past events that contribute to the dysfunction, the present events that trigger disturbance and the skills and internal resources that need to be incorporated for healthy and adaptive living in the future.

Very good results have been reported with the use of EMDR in persons who have been victims of a single traumatic event (Maxfield, 1999; Rubin, 2003). According to Shapiro, controlled research has found that approximately 85% to 100% of those with a single trauma can effectively treated in the equivalent of three 90-minute sessions (Ironson *et al.*, 2002). However, the same authors assert that in the case of persons who have been victims of repeated abuses in childhood, which have influenced profoundly the configuration of their personality, the treatment may be longer and more complex (Manfield, 1998). The explanation is that child's emotions and physical sensations can be triggered by a wide variety of circumstances in everyday life. However, one of the tenets of the

information-processing model is that personality constructs change as pivotal memories are adequately processed (Shapiro, 2002).

Primarily, the EMDR considers that the etiological event is encoded on a dysfunctional basis in the person's memory system. These unprocessed, dysfunctionally stored perceptions are seen as the foundation of the present pathological response. By using EMDR protocol an adequate processing of that information is facilitated. Very briefly, the patient is asked to concentrate on the representative or most striking mental image associated with the traumatic experience. In the next step, clinician helps the patient formulate a negative belief, the emotion accompanying the experience, and a positive belief especially suited to the target. Different ways of bilateral stimulation are used in the form of repeated sets of eye movements, tones or taps on both sides of patient's body. The patient is asked to focus on the target, the negative belief and the pshysical sensation and he is told to "let whatever happens, happen". The therapist acts as a facilitator and guide of the experience, but the process is made by the patient. The patient makes connections and associations which result in the change from dysfunctional perceptions to a more adaptive and healthy perceptions (Van der Kolk *et al.*, 1996). The new learning requires that connections between the present and past experiences have been done in the associative memory network. The nuclear with EMDR consists in potentiating the connections through the associative channels of the memory.

The EMDR focuses on body sensation rather than on language. In addition, it helps to integrate the emotional experience into the emerging narrative. These two features make this technique particularly useful in somatizing patients.

Hypnosis is a technique which can facilitate the recollection of the traumatic event and may be integrated coherently into different therapeutic models. Hypnosis provides the patient with techniques to mitigate and control the intensity and distress of the traumatic memory. It also can facilitate access to memories related to the traumatic experience which have remained enclosed in that experience, if the person experienced a dissociative state in that moment (Cardeña, Maldonado, Van der Hart and Spiegel, 2003; Erickson, 2003; Grindler and Bandler, 1997; Maldonado and Spiegel, 1998; Putnam and Carlson, 1998; Yapko, 1999; Zeig, 1992).

Hypnosis facilitates symbolic restructuring of the traumatic experience, provides a controlled access to the dissociated or repressed memories and help patients restructure their memories (Bremner and Marmar, 1998; Maldonado and Spiegel, 1998). Some authors have considered the hypnotic state as a controlled form of dissociation. Hypnosis facilitates the recovery of memories while allowing for some of them remain dissociated from cognition until the time the patient is ready to deal with them.

Maldonado and Spiegel (1998) consider that hypnosis would be indicated during the different phases of the therapeutic process. Thus:

Throughout the initial phases: Hypnosis would help to establish the therapeutic relationship and the setting, provide relief in the short term, make symptoms more manageable and improve the coping abilities. Hypnosis

may help by inducing relaxation, making suggestions for specific symptoms, anxiety, pain, etc., establishing a *safe place* or using procedures for the strengthening of the self. The therapist can train the patient in self-hypnosis techniques, so that the patient can put them into practice when he needs them without requiring the therapist's presence.

During the intermediate phases: hypnosis is indicated as a method for elaborating and integrating traumatic events. After the achievement of a solid therapeutic alliance, the most important goal is the integration of traumatic memories and not just their abreaction. It is probable that through hypnosis new memories arise or more details are recovered within the already conscious memories. It would be also helpful to go into integration and development, both relational and of the *self*, in greater depth. After the recovery of traumatic memories, the person needs to restructure the experience and achieve the integration of the traumatic memory within an adaptative perception of the *self* and of the world by potentiating the relational and personal development.

During the termination phases: training in self-hypnosis techniques may help the patient to cope with future potentially anxiogenous situations without the therapist's direct help.

In most occasions, after the therapeutic work, the person can even admit that "he did everything he could" under those circumstances. Throughout the "hypnotic imagination" techniques, the therapist may encourage the "person now", with his resources and abilities, to meet, embrace or comfort the "person then" who was being abused or traumatized. With the acceptance of the "victimized self", the person can also begin to recognize himself as a "surviving self" who made huge efforts to control the experience, move on, and become what he is now.

In this phase, hypnosis is helpful as it facilitates ways of "coping", such as self-hypnosis or other techniques such as age-progression, which helps to get over despair as regards the future and facilitates a personal, realistic goal for the subject's future offering more development possibilities to the person.

5.3 Termination Phases

During the termination, the therapist has to pay attention to the feelings relating to the elaboration of grief on account of the termination of the treatment.

The length and intensity of the treatment will depend on several factors such as the nature of the trauma, the existence of comorbidity with other disorders, and the time of beginning the treatment, amongst others.

The aim of the treatment of somatic symptoms, being understood as dissociative symptoms after traumatic experiences would be to complete the aborted freezing/immobility circuit allowing the discharge of the energy that is blocked, and which generates bodily symptoms.

The ideal way to express emotions is through the body channel. It is amazing how most of the therapeutic proposals have minimized, until a short time ago, the somatic or bodily experience of the trauma, and they have emphasized the verbal techniques which

in many cases only have access to the recollections of the declarative memory.

Therapy should include techniques that are included in the cognitive experience built by memories stored in the declarative memory, along with techniques related to the somatosensory emotional experience, built by memories, in the form of somatic markers, stored in the procedural memory.

Far from proposing a therapy exclusively focused on the body experience, we propose a therapeutic model which takes into account the psychobodily experience of the self-in-relation. The therapeutic aim is the co-construction, within a therapeutic relationship, of an emerging narrative in which the traumatic experience is integrated.

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