

Edited reprint from:  
Contra Costa Psychological Association Newsletter  
Spring 2009

**Current Approaches to the Treatment of Trauma:  
The Shift from Cognition to Affect Regulation  
Conference Sponsored by UCLA Extension and Lifespan Learning  
Institute – March 6-9, 2009**

*Summary by:  
Lorraine Granit, Ph.D.*

Presenters: Stephen Porges, Martha Stark, Dan Siegel, Allan Schore, Bessel van der Kolk, Pat Ogden, Diana Fosha, Francine Shapiro, Jody Messler Davis

As much as I would like to summarize the entire weekend, there is hardly the time nor space, nor have I fully digested this banquet of nourishing ideas. Perhaps I'll begin with a few of the take home messages. First, for those suffering from PTSD, whether from one incident or early ongoing traumatic parenting practices, there is no convincing them they are suffering from cognitive distortions. They do not feel safe and must be helped to feel safe at the neuro-biological level before change can occur at the cognitive level. Second, not all those who have suffered trauma develop PTSD. Research reveals that those from secure backgrounds seem to be insulated and resilient. Perhaps their prefrontal cortical connections to their limbic system are robust. Third, body-focused treatment has been shown to be an essential component of recovery.

It was Stephen Porges' work on the vagus nerve, one of the cranial nerves originating from deep in the brain stem that captured my attention. I have been following his research for several years and was looking forward to his presentation. He did not disappoint. I will attempt a nutshell summary of his astonishing work.

The vagus mediates our response to stress. It connects to the viscera, heart, lungs, HPA axis (hypothalamic-pituitary-adrenal), and the facial muscles and nerves. The oldest branch of the vagus, present in reptiles, is responsible for the freeze/faint reaction to danger, where the heart rate and breathing slow, the parasympathetic nervous system in humans is engaged, and the entire system becomes numb to pain and prepared for death. This system is activated when in

mortal danger, and/or danger where there is no escape (whether a reptile unable to outrun a predator, or a child being abused by those responsible for her safety).

The newer mammalian branch activates the sympathetic nervous system for fight or flight by up-regulating heart rate and breathing, shutting down digestion, causing the auditory nerves to scan lower frequency background noise, facial muscles to tense, eyes to squint, etc.

The third branch of the vagus is the real grabber. When one feels safe, then this branch facilitates social engagement. The heart and breathing are down-regulated in a controlled fashion, the face relaxes and eyes open and soften, and one is open to and signals readiness for social contact.

It is thought that those suffering from PTSD get stuck in the freeze/faint mode because of the inability or perceived inability to escape and the isolation of the traumatic event or events. Hence, triggering stimuli disable these people from taking effective action; like the patient of mine who froze up whenever a man made inappropriate advances because she was so traumatized by her abusive father. Her parasympathetic bias in these triggering situations precluded the possibility of sympathetic action, e.g. removing herself from the situation or assertively setting a boundary. Both Schore and Porges think of parasympathetic engagement as the physiological substrate of dissociation.

Porges believes that face to face therapy can sometimes be problematic since the social engagement system is not online much of the time for those traumatized. He uses sound to repair the social engagement branch of the vagal system in his research with autistic children. The vagus is hooked into the auditory system, as mentioned above, and music appears to stimulate the social engagement branch of the vagus. Within weeks he has autistic children smiling and making eye contact. I often suggest music to highly anxious and traumatized adult patients. Apparently it is more than an immediate stress reliever, perhaps facilitating healing of damaged nerves!

Pat Ogden and Bessel van der Kolk emphasize physical engagement. They recommend integrating physical activities into patients' lives as well as engaging patients at the physical level. Ogden finds that tracking bodily states is integrative. I find that to be true as well. Even if paying attention to ones' internal sensations, as one would in various mindfulness practices, produces no insights or catharses, the very process itself of attending to the body seems to unfreeze it and mobilize effective action. Directing attention in this way may be a way of connecting the regulatory prefrontal cortex to the dis-regulated limbic system which feeds into the

vagal response. Siegel refers to this process as vertical integration. Also, if I have a patient who begins to relive a traumatic memory, often I will get them up out of the therapy chair and moving around. This counters the frozen state of mortal fear and grounds them in the present.

I found myself thinking about the so-called alternative therapies I studied in the 70s, like gestalt, Gendlin's focusing, bio-energetics, and psychodrama, realizing that research is now enabling us to understand their healing power and re-integrate them into current practice. In fact, Ogden and van der Kolk spoke of using psychodrama as a way of enabling patients to engage in re-enactments with positive outcomes.

Siegel, Schore, and Fosha spoke to the healing nature of the therapeutic bond. Since those who are traumatized were often isolated and even betrayed by those who they relied on and have therefore diminished capacity to trust, the empathetic connection with a therapist also strengthens the social engaging and self-regulating prefrontal cortex. Current research has replicated results from a decades' old study that the therapeutic bond and the skill of the therapist correlated more strongly with successful outcome than type of therapy and any other variables.

No discussion of PTSD therapy would be complete without mention of the research showing EMDR to be highly effective in trauma recovery. Shapiro says that EMDR is not done in a vacuum and the therapeutic relationship and skill of the therapist are crucial. There was much talk about the neurobiology behind EMDR, including left/right brain integration.

Finally, I will leave you with a truly new and paradigm shifting idea. It was noted that depression is a consistent symptom of PTSD. It was also noted that most depressed patients have had identifiable early childhood trauma. It was suggested that depression may not be a separate psychiatric diagnosis but in fact in most if not all cases a symptom of PTSD. In fact, PTSD may be at the heart of most psychiatric diagnosis, that is, trauma, particularly early childhood trauma, causes psychiatric illness. Twin studies have revealed that in twins raised apart, psychiatric disorders often appear in only one, including psychoses. While genetics is a contributor, early life experience may be the strongest predictor.