Integrative Trauma Treatment: Expanding the Psychoanalytic Frame

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Abstract

Psychological trauma is a human condition that has been much addressed in psychoanalytic theory and clinical practice both historically and contemporaneously. Our purpose in discussing extra-analytic ideas and techniques and presenting clinical examples of their use is to introduce recently developed efficient and effective ways to resolve traumatic experiences that can be readily incorporated into psychoanalytic/ psychodynamic practice. Eye movement desensitization and reprocessing (EMDR) and somatic experiencing (SE) are the two primary modalities described in the two integrative trauma treatment cases presented. Both of these modalities utilize focused points of entry into implicit memories and self-states, and both offer a significant expansion in clinical effectiveness to the authors' shared relational psychoanalytic orientation. The cases, which include process notes, illustrate two different ways of moving patients along a trajectory to trauma resolution and post-traumatic growth.

Keywords

Psychoanalytic psychotherapy, trauma, integrative trauma treatment, memory reconsolidation

The Case for Extra-Analytic Techniques

Psychoanalysts from many schools have published accounts of successful resolution of traumatic experiences, beginning with Janet and Freud and on through to today (e.g., Boulanger, 2007; Howell, 2005; Krystal, 1968; Stolorow, 2007). Why then do we see an advantage to integrating extra-analytic techniques into clinical practice? There are at least four reasons for doing so.

1) Traumatized people may be incapable of verbalizing their experience. This may be because they are dissociated, because trauma occurred before they had language, because language and narrative areas of the brain were rendered dysfunctional by cortisol released under stress, and/or because traumatic memories were encoded into somatic, motoric, or imagistic form (Van der Kolk, 2014). Since psychoanalysis privileges verbal communication, extra-analytic approaches may be preferable or required in these cases.

2) Integrative treatment assumes, as does psychoanalysis, that the past informs the present. In psychotherapy, and particularly when using eye movement desensitization and reprocessing (EMDR) or somatic experiencing (SE), earlier memories may emerge quite dramatically and with intense emotional arousal. This evocation may exceed the analyst's capacity to regulate affect through relational presence and the treatment frame and may result in destabilization, dissociation, or even retraumatization. Specific affect regulation techniques are often employed to prevent these unwanted effects. A

deepening of resourcing may also provide for a more thorough reprocessing of traumatic material (Lepak & Carson, 2022).

3) The patient's traumatic experience may remain inaccessible because it either doesn't show up in discourse or become enacted in the transference. Extra-analytic technique can help to identify such aspects of implicitly held traumatic memory and bring them forward.

4) Extra-analytic techniques accelerate the process of trauma resolution. Learning to utilize them, or refer out to clinicians who do, therefore, becomes an ethical consideration.

Considerations when Working with Trauma

Traumatized individuals have unique clinical requirements. Those of us working with this population need to recognize and address the following five features.

Psychoeducation

The use of psychoeducation, usually at the outset of treatment, helps the traumatized patient to understand the nervous system's unique and specific response to trauma. We frame post-traumatic stress disorder (PTSD) symptoms as adaptive strategies in response to threats to survival, whether they are physical, emotional, or related to attachment. As people come to realize that their responses are understandable, common, and biologically based, they are usually profoundly relieved; they are not "crazy," and there is nothing inherently wrong with them. They are also reminded that they did indeed survive and that the therapy will help them to return to their pre-traumatic baseline. This reframing is an often important first step towards greater affect regulation, a reduction of shame, and the establishment of a therapeutic alliance.

Dissociation

Dissociation, the hallmark adaptation to traumatic experience, is understood in two different ways: first related to arousal level and second to structural changes in personality.

In the first usage, dissociation refers to an extreme physiological state which occurs during the traumatic event or while recalling the memory. For traumatized individuals, it is often a chronic state of daily life. Patients may be hyper-aroused (anxious, agitated, or frantic), or may be hypo-aroused (disconnected, numb, or shut down). The traumatized person may also experience dissociation as either depersonalization or derealization. While in these states, either they or the world do not feel entirely real, respectively.

The second use of the term refers to structural dissociation (Van der Hart et al., 2006). This occurs when the traumatic event is so disturbing that the nervous system's defense is to compartmentalize. This may include memory gaps, dissociated elements of traumatic experience, isolated self-states, or more serious splits in the structure of personality, as in dissociative identity disorder. Dissociated elements may include sensations, images, behaviors, affects, or meanings, which we conveniently refer to by the acronym SIBAM (Levine, 2008, 2010). Any of these may reappear decontextualized

as flashbacks, intrusive thoughts, wordless images, sensations, or movements. Which form of dissociation we refer to will be evident from its context.

Catastrophic Isolation

Catastrophic aloneness and helplessness are inevitable components of traumatic experience, even if others were physically present (Herman, 1992; Van der Kolk, 2014). Integrative trauma treatment and psychoanalysis share a relational focus which counters this. Witnessing the patient's traumatic narrative with empathic attunement disconfirms their expectations of continued aloneness and otherness. When the patient has suffered abuse or neglect at the hands of an attachment figure, these forms of relational contact are particularly vital.

In cases of attachment trauma, relational repair may need to be addressed before focusing on specific traumatic experience. Where there have been overwhelming attacks on one's sense of identity and safety, particularly when the source of trauma was an attachment figure, a sense of a reliable, trusted other needs to be restored or even developed for the first time. Specific extra-analytic techniques designed for this purpose may also prove useful, e.g., dyadic resourcing (Manfield, 2010) or developmental needs meeting strategy (Schmidt, 2004).

In addition, trauma-oriented group therapy can significantly augment individual treatment by developing the patient's sense of societal and familial/cohort belonging in ways that one-on-one individual psychotherapy, with a more parental transference, may not (Carson, 2020a). As a unique therapeutic modality, group treatment provides myriad opportunities to disconfirm relational expectations about self and other that traumatized patients hold, in particular, as regards their sense of aloneness, relational safety, and belonging beyond dyadic interactions and relationships (Carson, 2020a; Erskine, 2009; Herman, 1992).

Resourcing

Resourcing is the technique of invoking the patient's own capacities, positive memories, and associations in order to develop the resiliency needed to facilitate memory reconsolidation. Resourcing may be used during the preparatory phase before reprocessing or at various times during processing to enhance clinical effectiveness.

Physiological and Affective Dysregulation

Affective dysregulation refers to both hyper-arousal or hypo-arousal. States of hyper-arousal often lead to impulses to fight or flee whereas hypo-arousal often leads to freeze or collapse responses. In cases of ongoing relational trauma, collapse may take the form of an impulse to submit and attach, often with a pathological attachment to the traumatizing figure (Shaw, 2014).

The optimal range of affective arousal, i.e., the window of tolerance (Siegel, 1999) is one in which the patient is neither hyper-aroused nor hypo-aroused and is sufficiently alert to be both readily grounded in the present and able to access the past. By helping patients to remain within their window of tolerance, the therapist can facilitate the patient's processing of traumatic memory without their becoming unduly affectively dysregulated or potentially retraumatized. Any need for upregulating or downregulating the patient's arousal level is addressed prior to trauma processing, using various guided suggestions

of imagery, postural adjustments, or movements to either calm or enliven. Additionally, we gauge the patient's present-orientation throughout treatment, continuing to employ these techniques as needed. It is worth noting that successful trauma treatment often strengthens a patient's affect tolerance, thereby expanding their overall window of tolerance. As a result, the patient can both experience and tolerate a greater range of emotional arousal, both negative and positive, which greatly benefits the quality of their lives outside of the treatment setting.

Accessing Traumatic Experience

In order to determine the best point of entry into a particular patient's traumatic memory network, we first explore and assess the dimensions of the patient's experience using the SIBAM outline referenced above (Levine, 2010). Our goal is to determine which elements hold the most salience and/or valence to serve as a nodal point to which other dissociated elements of experience will be reconnected through exploration. EMDR and SE differ in their approach to this assessment.

SE, utilized in the case of Carol, finds the entry point into traumatic memory by guiding the patient into their felt sense experience (Gendlin, 1964). The therapist actively tracks physiological responses, and, in doing so, helps the client to discover, reintegrate, and process hitherto dissociated dimensions of traumatic experience. If the client is hyper-activated, the therapist may intentionally separate over-associated dimensions of experience to allow for effective processing within the patient's window of tolerance.

In the EMDR protocol, utilized in the case of Mary, the patient and therapist select an aversive memory that best captures the patient's chosen issue (a traumatic event, phobia, negative belief about oneself, etc.). The patient is then asked to go back to the remembered scene (image) and identify and/or rate other elements of SIBAM according to the EMDR Protocol. M (meaning) is accessed by formulating the subjective negative belief about oneself and the world in the present tense when the remembered image is brought to mind, e.g., "I am unsafe." Asked what they would like to believe instead, the patient provides a PC or desired positive belief (also a dimension of meaning) and a rating from 1 to 7, e.g., "I am safe now." The patient then identifies the emotion (affect) and bodily experience (sensation and behavior) that arises when accessing the memory, and also rates the overall disturbance of the memory from 0 to 10. Bilateral sensory stimulation (BLS) is next introduced. This may include guided alternating side-to-side stimulation via eye movements, beeps in headphones, hand taps, etc. BLS activates explicit and implicit components of the memory network as well as associated networks that contain positive memories and beliefs. During the pause between BLS sets, the patient is asked to relate their preceding experience, and the therapist can gauge progress and monitor arousal level. Often, these sets will advance the patient's own trajectory towards trauma resolution. Other times, judicious interventions are required. A full description of the protocols, processes, and underlying adaptive information processing model can be found in Shapiro (2018).

Introducing Extra-Analytic Techniques

Trust and confidence in the therapeutic relationship supports the patient's willingness to try a new approach. This often involves a significant change in discourse and sometimes includes changes to the physical arrangement of therapist and patient in the room. The therapist becomes more directive in instructing the patient what to do than in psychoanalysis. At the same time, the therapist remains receptive to the patient's experience of as well as to any negative reactions to the new technique. This may include feelings about the modality or negative reactions to the therapist in this new role. Every step forward is necessarily collaborative and the patient is never coerced into working in a new way. When patients are ready to proceed, the active choice and collaborative engagement in these new techniques can itself begin to counter the sense of powerlessness and helplessness that is embedded in traumatic experience. It is important to note that the trauma therapist needs to be alert to the possibility of command compliance as a potential habituated relational defense on the part of the patient (Eldredge & Cole, 2008). Bringing this very common survival strategy for traumatized individuals into the light of treatment can often offer a rich vein of exploration in its own right.

Transference/Counter-Transference Considerations

When we have isolated a specific symptom or issue and are preparing to use an extra-analytic technique, we address transference and countertransference issues only when they appear to be impediments to processing the traumatic issue. In the two cases that follow, transference and countertransference responses were mutually generally positive and facilitating. Had it been otherwise, there would be two options. First, we could address the issues within our primary relational therapeutic modality, or we might also invite the patient to explore their transference using the extra-analytic modality. It is important here that we take great care to determine whether the patient is able to engage their observing capacity or whether we need to take a more experience-near approach (Kohut, 1977) so that the primary focus becomes the patient's feeling blamed for their reactions. In this way we can avoid the pitfall of unwittingly facilitating relational retraumatization.

Memory Reconsolidation

Once the patient is sufficiently stabilized, resourced, and comfortable enough to try a new modality, we enter the heart of the work. Our goal is to facilitate memory reconsolidation**.** This refers to the process in which the traumatic experience or symptom-producing learning is elicited, transformed, and then returned to memory in an updated form. This process is distinct from memory extinction in that the old learning is not merely subordinate to the new learning but actually replaces it on a neurobiological level rendering the patient with symptom cessation that remains stable and enduring over time (Ecker et al., 2012). It is important to note here that the resolution of transference, intimated in the preceding paragraph, also carries out memory reconsolidation and is a, if not the, fundamental strength of relational psychoanalysis.

We understand symptoms to be expressions of originally adaptive emotional learnings that are at odds with current phenomenological reality (Carson, 2020b). These

emotional learnings are usually unconscious and non-verbal and are often referred to as schemas, implicit knowledge, or implicit relational learnings (Lyons-Ruth, 1998). To the person, these feel emotionally true and operate like facts: about the way things are—the way the person is, other people are, or the world is. When learned in the context of abuse, neglect, misinformation, or a lack of relevant information, they become harmful. Patients then misperceive what present-day stimuli actually signifies. For example, they may fear that intimacy *is* life-threatening, or that expressing their feelings means that they *will* be retaliated against, etc.

The process of memory reconsolidation (MR) begins by reactivating the implicit traumatic memory or implicitly held learnings about oneself, others, and the world (Ecker et al., 2012; Schiller et al., 2010). This needs to occur within a vividly felt emotional context. At the same time, an experience or learning that strongly varies from or directly opposes these beliefs is simultaneously accessed and brought into conscious awareness (Ecker, 2018). Simply stated, the heart of MR is the experiential disconfirmation of learned expectations, and as a result of successful MR, there is a permanent reorganization to the way that the patient engages with situations and responds to stimuli.

It is important to note that MR does not erase episodic memory. For instance, a patient may remember *that* she was sexually abused as a child, and even recall that she once had nightmares and was terrified of men. However, she no longer has bodily activation in sexual situations and no longer believes the trauma-induced prediction that all men are dangerous. Equally important, she is no longer filled with shame stemming from the belief that she was somehow responsible for what happened. Barring another sexual assault, her symptoms (sensory, semantic, and procedural memories of the events) are erased and/or revised, even though the factual narrative memory of the events are not.

We assume that all higher order memory changes in neurologically normal individuals involve MR, although the precise turning point for MR may or may not be directly identified/observed in session. For a more in-depth discussion of MR and how it may appear across various modalities, please see Ecker et al. (2012).

Additional Extra-Analytic Modalities

We are aligned with Erskine's view that integrative psychotherapy brings together elements of SIBAM within our patients' lived experiences (Erskine & Trautmann, 1996). The domain of our paper, however, is limited to consideration of those integrative approaches which have been particularly formulated for trauma treatment, carry out MR, and integrate well with a relational orientation. In addition to SE (Levine, 2010) and EMDR (Shapiro, 2018), these include sensorimotor psychotherapy (Ogden et al., 2006), internal family systems (Schwartz, 1995), accelerated experiential dynamic psychotherapy (Fosha, 2000), coherence therapy (Ecker & Hulley, 1996), and presence psychotherapy (Lepak & Carson, 2022). While a further discussion of these modalities is beyond the scope of this paper, familiarity with several of them is desirable in order to better match one's therapeutic approach with each patient's way of organizing and expressing their traumatic experience. The clinical presentations that follow demonstrate how various therapeutic modalities can be used not only to achieve MR but also to restore and enhance each patient's sense of self.

The Case of Carol (Psychotherapist: Gregory Carson)

Carol, a Caucasian heterosexual woman in her mid 40s, reported an uncanny feeling as though someone was going to hit her from behind with a 2x4. However, whenever she turned around, nobody was there. This repeated experience, which occurred primarily in the stairwells at work, confounded her and was causing her mounting anxiety. It seemed that her problem could be best understood as the result of an interruption to her natural defensive orienting response and that SE would most effectively address her symptoms.

Carol presented as intelligent, courteous, punctual, and engaged. She was in a good marriage, related well to her adolescent daughter, enjoyed her full-time career, and had a robust and satisfying social life. She also reported a regular meditation practice. This led me to believe that she would be able to tolerate the emotional intensity of trauma reprocessing after some initial work was done to diminish her chronic anxiety. Inasmuch as Carol was initially overly solicitous toward me, I kept in mind that she might have an anxious/preoccupied attachment style. If this proved to be an impediment to trauma processing, we would have addressed this issue first. If not, we might address her interpersonal style after the trauma work, depending on her goals for therapy. Carol's transference and my countertransference remained positive and facilitative during her year-long treatment.

Carol's initial idealization of her early family life soon yielded to a more distressing narrative. Her sunny picture of being her mother's confidante gave way to underlying feelings of resentment from believing that she needed to be her mother's caretaker. Her initial description of her father as a handsome, hardworking athlete and a successful physician transformed into a picture of a moody, agitated, self-involved, and socially awkward man who drank too much. Carol felt that she constantly worried about both of her parents but that no one seemed to worry about her. This manifested in the present with a preoccupation of imagining bad things happening to those that she loved.

Carol had been in a prior talk therapy in which her therapist had diagnosed PTSD stemming from a serious car accident, but this trauma had not been addressed. During college, while in a car with friends, one of whom was driving, she had impulsively grabbed the steering wheel when she imagined that another car was heading towards them. The car flipped, which resulted in serious injuries to herself and others. Afterwards, she was required to wear a halo brace and undergo neck surgery. I considered this experience a likely contributor to her fear that she would be attacked from behind. Additionally, the disastrous consequence of her mistakenly grabbing the steering wheel resulted in a deep mistrust of her own judgment which thereafter contributed significantly to her anxiety.

My attempts to attune to the nature of Carol's experience guided my choice of modalities. In this paper, I will focus on my use of SE; however, I also incorporated systems centered therapy, coherence therapy, and internal family systems.

To bind Carol's anxiety, I employed techniques from systems centered therapy (Ladden et al., 2006). Because much of her anxiety stemmed from negative predictions of the future, I helped her to develop a here-and-now orientation and to be curious about whatever might happen next. I then normalized Carol's fear of attack from behind, employing psycho-education to teach Carol how the body responds to traumatic events,

and I used SE to build her capacity for observing her felt-sense experience. In sum, these methods helped Carol to come into the present moment, calm her nervous system, and help her remain present and within her window of tolerance when her SE entered the territory in which her threat responses would be re-evoked.

A brief word about SE. This approach conceptualizes trauma as the result of disruptions to one's automatic sequence of defensive orienting to threat (Levine, 2010). In cases of PTSD, the sequence hasn't been completed successfully, e.g. the person is overpowered, rendered helpless, or flight from the relationship or situation is impossible. SE intervenes at the point at which the impasse(s) occurred, allowing for the natural release and completion of thwarted defensive responses via sensory tracking, and use of imaginary or symbolic motor actions.

I began by inviting Carol to attend to her sense of threat from behind by guiding her to explore the space 360˚ around her. I was looking for unprocessed memories of rupture to her peripersonal space either from the car accident, her subsequent neck surgery, or from something else that both Carol and I might not yet be aware of. The body will often reveal what cannot be accessed through words.

I guided Carol to look for changes in tension, sensations, emotion, images, meaning, etc. while I looked for changes in her posture, the bracing or relaxing of musculature, or changes in facial expressions that indicated her having located something. I also attended to my somatic countertransference, for the possibility of resonances that might suggest what Carol was experiencing. Throughout, my main task was to keep her within her window of tolerance so that she could effectively reprocess whatever she encountered. As session time wound down, I gently reoriented her back to the here-and-now.

SE requires that the therapist refrain from sharing interpretations or hypothesized narratives and rather to trust that tracking nonverbal experiences will lead to both trauma resolution, and very often, the reformulation of relevant narratives. In Carol's case, I assumed that a "clamping down sensation" she reported in her neck was likely connected to her car accident and/or surgery. Interestingly, this proved incorrect. What emerged instead was a physical representation of holding back and keeping things to herself to avoid being shamed or abandoned. The somatic approach revealed another layer of Carol's relational adaptation, and I utilized coherence therapy to bring into awareness Carol's implicitly held belief for the emotional necessity of clamping down. The experience of identifying and openly sharing this early pattern, with an attuned listener, served to disconfirm her implicitly held belief that no one would ever stay present with her in her underlying vulnerability or negative affect (Ecker & Hulley, 1996; Ecker et al., 2012). Carol was able to both observe and experience the genuine felt sense that her experience mattered to me and that she didn't need to "hold back" by keeping everything to herself. This empathic attunement, a bedrock of psychoanalysis, helped to further carry out memory reconsolidation.

Returning to SE, we tracked discrete sensations along Carol's forehead which led her to recall a previously dissociated felt-sense memory of wearing a halo brace and being told by doctors not to move for risk of causing irreparable damage. She remembered her shock at being alone when she was informed that she would need emergency neck surgery. The sense of threat from behind (stairwell anxiety) was, at least in part, related to feeling overwhelmed at having to make such a consequential decision

by herself. Carol's mother claimed to be too upset to visit and her father was, as usual, largely absent. Here, our therapeutic relationship proved crucial. Again, Carol was able to experience my presence and empathic attunement as an experience that disconfirmed her sense of insignificance and aloneness (Fosha, 2000) and her implicit belief that no one "had her back." As a result, we were able to work with neck sensations that related to childhood experiences of aloneness, vulnerability, unmet need, and resulting shame as well as those related to her surgery.

Experiences that occur under general anesthesia often remain alive in the body and require somatic expression (Osterman & Van der Kolk, 1998). As we continued to explore the space around her, Carol reexperienced the nervous system activation associated with her neck surgery. This arousal was the result of thwarted survival responses related to peripersonal boundary violations including intubation and being placed face down on the operating table with her spine exposed. I believe the presence of these unprocessed traumatic experiences in Carol's nervous system expressed themselves on a somatic level as significant elements of her underlying paradigmatic anxiety and bodily tension. In session, we were able to discharge[1] the feeling of powerless subjection to invasion from intubation as well as the successful completion of an adaptive defensive sequence through an imagined flight from the imprisonment of the strapped-down surgery. In the sessions that followed the reprocessing of her intubation and surgery, Carol came in reporting feeling lighter, happier, and freer.

In subsequent sessions, self-states holding traumatic experience (both relational and situational) would emerge non-sequentially (Bromberg, 1996). These were addressed in whatever order they arose: being taped to a board at the crash site, negotiating with herself immediately after the crash whether things were really that bad, a thwarted startle response during surgery, being in traction post-surgery, anger at her father for burdening her further when she was helpless in the hospital, freezing before the other car's impact, the collapsing of space around her during impact, recognizing implicit family messages that promoted keeping family emotional truths hidden from oneself and others, the car rolling after impact, being an 8-year-old un-seat-belted passenger in the car while her father drove home drunk from holiday parties, fears of losing consciousness/control (perhaps under general anesthesia), etc.

Following these sessions, Carol reported being able to express her needs and differences more often and more easily (including disagreeing with her father), and being free from anxiety in situations in which she formerly would have felt fearful. From an IFS perspective (Schwartz, 1995), Carol's difficulties could be seen as stemming from self-protective parts that, on their face, appeared to be destructive. Through incorporating an IFS approach, I was able to help Carol's adult observing self compassionately recognize that her anxious self-doubting part and her hypervigilant self-critical part both served vital functions. By bringing her to focus on what she lacked, they each effectively distracted and protected her from reexperiencing her underlying sense of feeling out of control, helplessness, and looming serious danger that resided in her traumatic memories. These

1. In our usage, discharge refers to allowing the body to release energy that has been stuck due to trauma.

unconscious protective strategies were rooted in implicitly held learnings which originated in her family-of-origin and which were reinforced by the car accident, her subsequent surgery, and frightening post-operative time spent alone in the hospital.

At one point, Carol wondered aloud if she might be under-worrying. When I invited her to explore what now resided in the bodily space her worry used to inhabit, she described a new and novel experience of pleasurable spaciousness and playful rejuvenation. I understood this as a direct outgrowth of feeling safe in a body now freed up from containing thwarted and trapped survival responses and one in which she could now expand her ability for positive affective states (Leeds, 2006) and the engagement of her seeking and play systems (Panksepp, 2004).

It is not always necessary to verbally formulate implicit trauma memories in order to resolve them. An example of this occurred when, ten months into therapy, we processed newly occurring uncomfortable and puzzling sensations that extended down the left side of Carol's body. Although no verbal narrative emerged during SE processing, in her next session, Carol reported that she was now able to walk in the stairwells at work without any distress. Carol's sense of danger had been resolved through working with its somatic representations.

After just over one year, Carol successfully terminated treatment, leaving the door open to future work should she so wish. At termination, Carol had cleared her sense of threat from behind, evidenced significantly improved capacities for self-trust, self-expression, relaxation, and joy, and she possessed a far greater facility for being present-oriented and curious in the moment. Carol now saw others as having their own perspectives and reported marked differentiation from her lifelong role of caretaker. This stood in beautifully stark contrast to her anxious preoccupation with bad things happening to loved ones through either her impulsivity or lack of vigilance, which comprised so much of her experience at the outset of treatment.

The Case of Mary (Psychotherapist: Sandy Shapiro)

The case of "Mary" which follows illustrates the integration of EMDR into a long-term relational psychoanalytic psychotherapy. Treatment resolved specific childhood traumas, dissociation among self-states, and achieved a degree of maternal attachment repair.

Mary, a 64-year-old Caucasian, heterosexual, single woman, spent a chaotic and unhappy childhood in an isolated rural area with an older brother and their suicidal, depressed mother. Their father was unreliable, alcoholic, and left the family when Mary was 11 years old. When she was less than 14, her mother committed suicide. This was followed by Mary being shuttled among unwelcoming family members.

Mary had a lifelong history of major depression, including one hospitalization for suicidality and a chronic reliance on a variety of antidepressant medications. She had a succession of female therapists throughout her adult life, including a long-term treatment with me. While Mary's symptoms of major depression were finally treated successfully with electroconvulsive therapy (ECT) and maintenance-level anti-depressants, residuals of her traumatic childhood remained unresolved, and these were targeted throughout treatment with EMDR.

My countertransference tended towards the maternal, and in retrospect, my desires to be a positive maternal object for Mary may have potentially inhibited her from needed expressions of forbidden affect. Fortunately, by being able to reprocess early traumatic memories with EMDR, most importantly the kitten trauma which follows, I was able to facilitate Mary's expression and resolution of lifelong guilt in relation to murderous wishes.

When Mary was about 4 years old, she discovered a feral cat with a litter of kittens and took a favorite kitten for a pet. She left the kitten in her closed toy box in the garage. At least a day passed before she remembered the kitten and found it dying. Mary hoped that EMDR, which she had previously experienced with success, would resolve this hauntingly painful memory.

Mary vividly, tearfully, imagined the kitten's terrible suffering and felt hateful and without compassion for her child self. Mary was generally able to be in a present-oriented adult self-state in therapy. However, while processing the kitten episode, the dissociative splits amongst several self-states were clearly reflected in her changing use of different personal pronouns ("I," "She," "We"). These fluctuations in Mary's use of personal pronouns suggest changing identifications with her mother as abuser (when Mary blames herself for harming the kitten), and with herself as an abused child/abused kitten.

I hypothesized that Mary had harbored hateful fantasies of her mother's death, but that these fantasies were caught in the insoluble bind of being attacked, abandoned, and then losing any possibility of being loved, if expressed. Rather, Mary enacted the moral defense (Fairbairn, 1943), preserving her relationship with her mother by enacting her own badness in holding her child self responsible for killing the kitten.

A month-long course of EMDR (including extended sessions) was aimed at helping Mary to resolve her intense feelings about the unintended death of the kitten, but as we will see, this opened up the more fundamental issue of maternal attachment.

Session One

Mary's initial EMDR focus was on the image of finding the kitten "not asleep." We co-constructed her negative cognition/self-belief as "I am dangerously careless." Her desired, positive cognition/self-belief was "I can take responsibility and learn to forgive myself," which Mary rated as a modest credibility of 3 on a scale of 1 to 7. Emotions: "guilt, shame, great sadness." Body sensations: "discomfort, from the top of my head to the base of my spine."

During BLS sets, Mary imagined how the kitten felt, "crying and screaming," until it became exhausted. She then reflected, "my own mother could do that to me" (treat her as she had treated the kitten).

Session Two

Mary reported that her somatic symptoms from the previous session had disappeared, and she attributed their dissolution to EMDR. She now reported experiencing "a massive clump of major depression." When we returned to the kitten trauma, Mary engaged her adult self in the reprocessing of traumatic memory, saying "we needed to bury the kitten and put a cross on the grave in the back yard." At this point, I suggested a parallel by saying, "Yes, and the right kind of mourning didn't happen with your mother either. That, too, has yet to be resolved."

Session Three

Enacting the cycle of her ambivalence, Mary returned to a more familiar self-state, "I have no compassion for myself as a child." In response to Mary's shift back to self-blame, I encouraged Mary to re-engage her adult self to accompany this child in whatever way felt authentic. She said,

> I ended up taking the kitten into the house. I fed it from an eye dropper, with a mixture of sugar water and a pinch of salt, and sent the child off to see if she could find the mother cat. I told the child what I was doing, keeping it warm, giving it fluid, but that if we couldn't find the mother, it probably won't live; it's too young. (When it died) We dug a hole, and I told her that everything that is born and lives ends up going back into the earth, making it better for things to grow. I told her this kitten died too soon, and I'm not allowed to take a kitten from its mother. That was a mistake, but it was a bad mistake… she was still responsible for the mistake.

I contrasted Mary's respectful stance with her mother's cruel verbal treatment. I supported a differentiation between adult Mary and child Mary by asking "so, how does this child feel after being shown how to try to save a life, being given a role in trying to save it, and then burying the kitten when it died?" I then resumed BLS to facilitate Mary's formulation and expression of her own reactions to this question.

Mary, standing in the spaces (Bromberg, 1996) and speaking for the child, said "I still feel shame, but I feel more respected." Then immediately, Mary (as adult) said, "I'm glad there was not an erasure of responsibility. There was a mistake, but a bad one." I saw this as progress towards Mary resolving her self-hatred. The child felt less shamed. The adult Mary still felt strongly about responsibility but was less blaming and emerged into a nascent self-state of a kinder mother. And finally, there was a shift to "we" as Mary joined with her child self to plan a memorial ritual for the kitten. Significantly, Mary later reported that her recent depression had lifted after this session. And at the end of this session, Mary reported greater conviction in her positive belief, "I can learn from my mistakes" (now a 5, on a scale of 1 to 7).

Session Four

In this session, Mary wanted to shift to her feelings about her mother's death. She knew intellectually that she didn't kill her mother, but she still felt guilty knowing that, at the funeral and thereafter, she had felt relieved and even glad about her mother's death.

I asked, "Could you ever have been the perfect, good child who healed her or stopped her suicide?" Mary responded, "No!"

This intervention probed Mary's felt sense of responsibility for her mother's ill treatment of her. Her response clarified that her previously implicitly held belief that she was to blame had been disconfirmed.

Session Five

Mary's choice of EMDR target image changed to putting the kitten in the toy box. She recalled "I felt then, this is naughty, not right," and that feeling naughty was a pleasure**.**

I suggested that she wanted to be naughty but not to kill the kitten. Mary replied, "Yes. I never felt like I murdered the kitten. Being stupid and killing the kitten, yes. Negligent…"

I said, "The act was intentional, but the death was unintentional."

A set of BLS followed in which Mary was able to convey this distinction in an imagined interaction with her child self. As dissociation between child and adult self-states diminished, Mary's implicitly held belief that she is bad was further changed in favor of compassionately understanding that she was only a child. This new view of self was then reconsolidated into a revised memory of the kitten's death.

Session Six

As evidence of MR, Mary began the next session reporting that the kitten scene had lost most of its associated distress (now a 2 on a scale of 0 to 10 and by session's end a 0). Her thoughts next turned to her mother's chronic depression and suicide attempts. She said, "I finally have come up with a logical reason that will filter down to my heart and stomach. The 13-year-old wasn't guilty about her suicide. Those suicide attempts were *hers*, not mine, not my father's. Yes, I was an obnoxious, nasty, brilliant 13-year-old, but… I didn't *kill* the kitten. And much less did I *kill* my mother… which makes me think, how do I mourn the woman whom I loved and hated equally?"

Mary's open question marked a profound change in stance from the self-hating, traumatized woman she had been. She had traveled far: from resolving a concrete, single-episode (kitten) trauma to uncovering her core issue of ambivalent attachment (Ainsworth et al., 2015; Bowlby, 1988). Although I had understood that EMDR could facilitate the exploration of Mary's attachment trauma, Mary had not expected her conflict with her mother to emerge, no less to be resolved. Mary agreed, "Yeah, who'd have thought the kitten memory would go to this?"

Mary had now learned that positive change can come from negative experiences. With additional sets of BLS, Mary rated her positive cognition/self-belief, "I can learn from my mistakes" at the maximum value of felt-sense credibility (7, on a scale from 0 to 7). The trauma of the kitten's death has remained resolved thereafter.

When trauma involving a death is resolved, authentic grief and mourning often follow and need to be processed. Mary was able to reimagine her mother's funeral during sets of BLS without undue arousal. She no longer felt the shock from her mother's suicide, responsible for her mother's death, or guilty for feeling relieved at her mother being gone. Mary planned and subsequently carried out a number of her own creative and meaningful rituals which allowed for her to accommodate this early and traumatic loss.

Mary and I agreed that her hospital-based ECT for her life-long treatment-resistant depression was a crucial prerequisite for her successful trauma treatment. Flooding depressive affect is enervating, places the person outside of their window of tolerance, interferes with clarifying sources of their depression, and precludes one's fully experiencing other emotions. ECT's resolution of Mary's depressive disorder, however, did not in itself resolve either the kitten trauma or her core attachment trauma. Mary and I agreed that is was EMDR which had facilitated their resolution.

Mary's life became much more expansive after this phase of treatment. She traveled, reached out to friends, and she opted for continued recovery and growth in joining a group led by a therapist who works with trauma. In the end, Mary was able to risk intimacy, enjoy the benefits of being with others, and see herself as a member of shared humanity.

Discussion

The case of Carol represents an integrative treatment in which a number of modalities are woven together to address and resolve striking somatic symptoms, a problematic developmental history, implicitly held situational and relational trauma, and a lifelong defense of anxious preoccupation. Her presenting complaint of feeling the threat of attack from behind offered a clear pathway into her underlying and implicitly held experience. SE, which I initially used to explore boundary ruptures to her peripersonal space, opened the door to related developmental and relational issues of invasion, abandonment, dependency, and trust. The use of system-centered psychotherapy early in her treatment helped Carol to sufficiently manage her anxiety, and the later integration of coherence therapy and internal family systems helped Carol deepen her awareness of and bring compassion to the various unconscious protective strategies that kept her underlying traumatic experience at bay. I combined these approaches with an empathic attunement born from a long-standing relational psychoanalytic psychotherapy practice. This allowed for in-vivo and felt-sense disconfirmation of implicitly held memories which contained relational and somatic aspects of trauma from Carol's childhood, the car accident, her subsequent surgery, and her post-surgical time alone in the hospital. Working in this manner allowed for the further disconfirmation of her implicitly held beliefs of needing to hold herself back and attend to others which was learned in childhood and reinforced throughout much of her life. Carol's relatively rapid alleviation of trauma sequelae as well as the deeper and more fundamental reorganization of how she viewed herself and others strongly support the choice of an integrative, multi-modal approach in this treatment.

In Mary's treatment, the integrative approach of EMDR and psychodynamic psychotherapy resolved the specific kitten trauma, but it also brought into awareness and resolved her ambivalent maternal attachment. While the question of whether she could now actually forgive her mother remained, it did not impede Mary's emergence into a freer and more expansive life and sense of self.

Although Mary's treatment with me ended with my retirement from clinical practice in 2018, she was very pleased to participate in follow-up communications. She reported that five years after the EMDR phase of therapy had ended, she evidenced continued resolution of guilt and shame, improvements in self-compassion, and the valuable ability to hold ambivalence without dissociation. Further evidence of the clinical effectiveness of our work emerged more recently after a depressive episode during the COVID-19 pandemic, which she attributed to her persisting post-virus symptoms and to social isolation. This latest recurrence, however, neither reversed nor destabilized the treatment gains she made via EMDR-facilitated memory reconsolidation.

Conclusion

Emotionally meaningful learning and relearning in all effective psychotherapies involve memory consolidation (in treating developmental deficits) and memory reconsolidation (in the unlearning and relearning that is central to therapeutic reprocessing). Both of these may be achieved through the use of a variety of therapeutic approaches (Carson, 2020; Erskine & Trautmann, 1996; Frank, 2020).

As analysts, we focus on the story of our client's lives as worded, meaningful narratives and typically co-create new versions in the course of psychotherapy. Words are a powerful form of symbolic encoding. They enable us to create emotionally explicit, labeled, and semantically nuanced categories of experience (Bucci, 1997). These consolidated encodings may express our truths on the one hand or rigidly maintain our protective strategies on the other. By integrating experiential modalities such as EMDR and SE, we can facilitate the revision of one's life narrative beyond semantic memory to include the reprocessing of somatic/sensory and procedural/motoric memories. These may not emerge or be processed in a less experiential verbal psychotherapy. In addressing these other dimensions of implicitly held experience, we can help clients shift their narratives in ways that are not possible otherwise. Both cases presented demonstrate the importance of nonverbal processing without sacrificing the patient's capacity to put their newly recognized and/or newly created experiences into words.

There is presently no convincing prescriptive indication for the choice of treatment modality for specific trauma symptoms. It is our contention that competency in a variety of modalities considerably facilitates the clinician's ability to address and resolve a variety of traumatic sequelae. We hope that these case examples and our prior argument supporting the use of extra-analytic techniques have served to demonstrate both the advantages of an integrative approach and the need for special considerations in working with those affected by trauma.

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