Infant Research
&
Neuroscience at Work
in Psychotherapy
EXPANDING THE CLINICAL REPERTOIRE

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that helped him in moments of anxiety; it also held an important message for him that contained and summarized many of our interchanges about his phobia and also helped him to hold our therapeutic work and me in mind when he repeated it to himself.

Panic Disorder

In panic disorder, the internal experiences of physiological bodily changes (e.g., hyperventilation, quickened heart rate) reinforce and accelerate the panic (LeDoux, 1996). As the person becomes aware of these bodily changes, he or she becomes increasingly anxious. It is a self-perpetuating escalating cycle. Often, patients who have had several panic attacks begin to panic about the possibility of a panic attack. They then avoid situations where they think they might experience another one.

Understanding the fear system shifted the way I work with patients prone to panic attacks. Previously, I would try to understand the triggers and help the patient make the psychodynamic connections between specific events and panic attacks. However, I never found that approach particularly effective. Once understanding how the fear system works in panic attacks, I changed my approach. I now explain the brain physiology to patients as a runaway train. I teach them to close their eyes, whenever and wherever they find themselves either in the beginning or in the throes of a panic attack, and to slowly engage in deep breathing. I work with them to find relaxation techniques that are specific to them. I often recommend medication to be used on an “as needed” basis when they feel a panic attack starting. All of these tools give patients a sense of control over the panic and reduce their feelings of shame around the reaction. Once these tools for managing the panic are in place, I return to the more usual therapeutic stance that connects the panic to specific psychodynamic triggers. I found that giving these patients tools for managing the panic first gives them a sense of control, and creates a feeling of trust in me and a beginning sense of safety in the therapy that serves to facilitate psychodynamic work.

Trauma and PTSD

Finally, the neuroscience of fear is particularly useful and relevant in working with trauma and PTSD. Most researchers agree that PTSD is a response to phenomena that are far outside the realm of ordinary life experience. Learning about the fear system, memory in trauma, and the nature of emotional memory has dramatically shifted the way I think about, and work with, patients suffering from PTSD. Almost anything can remind a patient of the traumatic experience. Once triggered, intense panic and destabilizing emotional memories flood the person, who is suddenly in the throes of an uncontrollable psychic tornado.

In the past, working from a top-down approach, emotional release as a treatment for PTSD was considered a desirable approach. Yovell (2000) delineates the differences between the older approach toward PTSD, namely, emotional catharsis, and the newer approach that integrates the neuroscience of trauma. Yovell suggests that, when a patient is in the throes of reliving aspects of past trauma, the therapist avoid interpretations that connect past and present. Instead, he points out that interpretations are potentially less overwhelming and fragmenting once the patient has regained
composure, thereby making it easier for the patient to integrate past emotional trauma with present behavior. The approach suggested by traumatologists, who work from a bottom-up approach, described above, also assumes that the emergence and/or experiencing of aspects of the trauma will have a destabilizing effect on the patient. Both approaches require the therapist to serve a structuring, containing, and deeply empathic role in the face of overwhelming and destabilizing emotions (Eldridge & Cole, 2008).

Memory in trauma emerges in fragments, with a lot of uncertainty about its veracity. The memories (1) are hyper-arousing and disorganizing for the patient, (2) can be triggered by the slightest external stimulus, (3) might hold bodily sensations that went with the original experience, and (4) are often shrouded in shame. The shame derives both from the original experience, which was affectively encoded, and from the patient’s current experience of not being able to manage the overwhelming feelings more effectively. In other words, the patient feels shame for appearing and feeling out of control.

My colleague Heather Ferguson shares a sensitive handling of the emergence of traumatic memory, using a top-down approach, that exemplifies a clinical process that embodies all the issues described above as a way of working with trauma: it demonstrates (1) the disjunctive way in which traumatic memory unfolds; (2) the uncertainty around events as remembered; (3) the anxiety, fear, and shame associated with the emergence of traumatic memory; and (4) the trust, confidence, and courage required by both patient and therapist in entering the trauma territory. The clinical work is presented in the first person, with “I” being Heather Ferguson.

Heidi: The Emergence of Traumatic Memory

At the age of 30, Heidi, a highly successful corporate executive, began her first therapy experience. During her first year of treatment, Heidi exposed the depth of her pain as she identified unbearable feelings of emptiness, hopelessness, and despair. She drank to “numb out,” then, finding herself intoxicated and disoriented, she would cut her wrists with sharp objects. During these episodes, Heidi described feeling overwhelmed with self-loathing and shame for her neediness.

Heidi slowly and tentatively shared her history: She began drinking at the age of 12, and at the age of 14, began making delicate cuts on her hips and wrists. She felt shame about these symptoms as she recounted a lonely childhood and described her ever-present wish then that her parents had deciphered her signs of distress. During this first year of therapy, numerous signs pointed to the possibility of a sexual trauma history. Heidi presented an extreme split between a hyperfunctional grown-up self at work and a more fragmented and vulnerable self revealed at night, when excessive drinking and cutting would occur. These behaviors had an involuntary quality marked by a disconnection from any felt danger. They served a dual purpose: They provided self-soothing, albeit temporarily, and they blanked out emotional flooding. Later, Heidi said it was as if she needed to “drown out” the memories with alcohol.

Heidi haltingly described early memories of painful genital self-stimulation and compulsive sexual enactment with a younger neighborhood boy. These descriptions had a detached, driven, and compulsive quality. As Heidi described
hurting her vagina, she sat in a frozen position, her gaze turned away, terrified that I would reject her as overwhelming or disgusting. Hypervigilant about any possible negative reaction on my part, she needed direct reassurance from me that I was not horrified by these revelations. I inferred that she was hyperaroused as part of the original emotional trauma.

I reassured Heidi that I was not “disgusted” by her disclosures and that I wanted to understand all that her early behavior meant. The early onset of Heidi’s symptoms and her history of extreme dysregulation and self-harm clearly pointed to a traumatic past. Gently, I asked if anyone had inappropriately touched or hurt her in any way. She said that she had no conscious memory of any inappropriate or sexualized contact. I proceeded very cautiously with this material, as I did not want to retraumatize Heidi and cause her to shrink from sharing more details of her early overwhelming experiences as they began to emerge.

During this time, I was deeply concerned about Heidi’s alcohol use and fragile self states. I suggested alternative treatment possibilities for the drinking; we tried a harm reduction approach with mixed results. After she spent an evening of drunk driving, cocaine use, and sex with a junior colleague, I took a firm stand: it was time to commit to an experiment with sobriety because controlled drinking was not working. Heidi agreed; she was fearful of losing our therapeutic connection, which had become a vital source of security for her. We added a sobriety support group, hypnosis for anxiety, and an increase in the frequency of our sessions in order to support Heidi’s brave first ventures into sober living.

Heidi responded to my firmness around her drinking with relief. She experienced me as a source of strength, someone able to set firm limits, and provide caring qualities. She remembered her childhood as woefully barren of any caring or nurturing. Later on, she said, “I think I wanted to put an end to the madness and chaos.” She acknowledged that my firm stance in relation to her drinking was central to her evolving sense of trust and safety in our relationship. She noted that I disconfirmed her expectation of neglect and proved that I was sturdy enough to both keep her safe and hear the “real” story that was beginning to surface. I believe that the caring and strength conveyed in my therapeutic stance created the space and emotional context for her terrifying and dangerous memories to emerge and live between us.

Heidi stopped drinking and cutting. As she relinquished these symptomatic behaviors, she began to share more vulnerable feeling states. And, for the first time, she reported vague memories of sexual violation at the hand of her beloved maternal grandfather who had died 13 years earlier. She shared these newly emerging, snapshot-like images of her grandfather, first bouncing her on his knee at age 5 and later inserting his finger into her vagina. She said, “It was as if he was trying to trick me, as if I wouldn’t notice.” As is often the case as traumatic memories surface, they emerged in bits and pieces. And, as is also typical of the emergence of traumatic memories, Heidi expressed a lot of confusion. She vacillated around the veracity of these memories. Although I believed in the veracity of these memories, I maintained a curious and open stance, reassuring her that we would hold the details lightly. I did not want to prematurely rush or force anything that might overwhelm and retraumatize her.

Heidi was deeply conflicted about the possibility of having
been sexually violated. She wavered between utter disbelief, fear, and mortification that it might be true, and terror of what it might reveal about the nature of her relationship with her idealized grandfather. Repeatedly, she asked me if I thought she had been sexually abused. As is often the case with traumatic memory, she needed validation that what she was experiencing was indeed horrible. I told her that given her early symptoms of self-harm and the newly emerging memories, I did think that she had been sexually abused.

No longer anesthetizing or self-medicating with alcohol, and with my validation and support, Heidi’s childhood memories crystallized and entered her conscious awareness. She revealed painful feelings of being on the “outside” of her family, feeling overlooked and painfully alone. She speculated that the lack of an intimate and safe connection to her parents made her vulnerable to her grandfather’s overtures. And, through his violations, in her mind she became his special one. We underscored the double relational trauma: first, the absence of her mother as a containing and mirroring presence and, second, the betrayal by her grandfather, previously a source of comfort.

Now that the memories, although vague, were out in the open, Heidi began to search for clues to piece together a coherent narrative of her early experience. She pored over childhood photos and home movies. An evocative dream revealed the experience of being robbed of her childhood innocence, left alone in dreadful anticipation, as her mother’s self-absorption and neglect left her vulnerable to her grandfather’s sexual violation.

Months later, Heidi blurted out that her grandfather had, in fact, touched her sexually, although the details and frequency of their sexual contact remained unclear. She later acknowledged the power of this shared experience. She remembered the nature of the trauma, explicitly, for the first time in my presence. Intrusive memory fragments—visual images like a looming finger or a shaft of light on her childhood bedroom wall—emerged with a hyperintense quality, often disrupting Heidi’s sleep or concentration during her waking hours. At other times, heightened somatic memories, like the feel of vaginal clenching or the touch of fabric, came unbidden. As the nature of the physical violation became more certain over the months, Heidi experienced an increase in emotional dysregulation and disorientation. Her sleep, eating, and work schedules became highly erratic. Vivid nightmares would wake her, disrupting her sleep, and Heidi found herself hiding out in her bed, fearful and anxious to begin her day.

Heidi’s seriously impaired sense of time evoked significant alarm, particularly after she hit a pedestrian with her car when she found herself “spacing out.” She was plagued and startled by unwanted flashbacks, images, or words, a consequence of her traumatic experience. As is often the case in working with the emergence of previously dissociated traumatic memories, the presence and availability of the therapist as a sustaining and stabilizing force is essential. During this time, Heidi kept in touch with me via frequent e-mail and phone contact. These contacts seemed to have a stabilizing effect and reassuring influence, offering her the needed containment and reassurance that I was closely tracking her experience; she was not alone with her terror and fragmentation. We often discussed the communication, in person, the following session.
Heidi continued to feel chaotic at work, unable to focus and show up on time. After many months of chronic lateness, she was fired from her high-powered job. This was a devastating blow because work was the primary source of her self-esteem. However, it gave us the opportunity to meet intensively (four or five times per week) and to construct a coherent narrative about her traumatic past. Over time, Heidi experienced having one story, instead of many, as we reconstructed her past together. Creating a coherent narrative is crucial in working with trauma because it helps to ground the person in the validity of his or her own experience (as awful as it may be) and to give the person an explanatory framework that helps to make sense of his or her experiences.

The loss of her job and the dismantling of her hyperfunctional work identity was a turning point in the treatment. For the first time, Heidi deeply connected her abiding sense of shame with her childhood sexual trauma, previously disavowed and sequestered from conscious awareness. Heidi felt newly committed to recalling the details of her traumatic memories—with all their affective intensity—in my presence. She began to notice and feel more connected to shifts in affective states in her sessions, increasingly able to acknowledge and identify anxiety and terror in the moment. As a result, Heidi experienced a more grounded and cohesive self-experience in and out of session.

Slowly Heidi became aware of a deep sense of mourning for all that had been lost and would never be, particularly her experience of childhood innocence. During this time, Heidi often felt intense fear that she might drive me away with her shameful neediness or some unintended provocation. When I commented that at these heightened affective moments, it seemed that her fear system was overriding her attachment system, Heidi felt a deep sense of recognition.

Increasingly, Heidi began to trust her own perceptions regarding her recollections of the past. We explored new connections to the protective role that her symptoms had served (e.g., alcohol drowned out memories, and cutting served to release the grip of her grandfather’s imprint). And I helped her to learn ways to bracket her experience when traumatic images or feeling states flooded over her. One of the techniques was to call on her reflective and observational capacities to remind herself that she had already survived the trauma—it now belonged to her past—and to reinforce her sense of safety in the present. Slowly, she began to have an emerging sense of unfreezing the past from its grip on her present life.

Concurrently, Heidi eloquently described her growing capacity to conjure up her attachment to me in times of need: “For as long as I can remember, I’ve clung to a fantasy of a maternal figure comforting me... any time I felt sad or vulnerable, scared or anxious, I’d cue up my fantasy replete with longed-for, yet never-experienced, visual, auditory, and tactile elements. Absent the experiential component, I tried to imagine what this maternal figure looked like, what the tone of her voice sounded like, and how her touch would feel. I could see her, but she was without a face... I could understand her words, but she was without a voice... I could picture her holding me, but I couldn’t feel her. When I’m full of hurt these days, I still flip the switch on my fantasy... the same scene emerges, but now I can see her kind face, hear her gentle words, and feel her soothing touch—she’s you.”
The case of Heidi shows, in experience-near terms, essential but fairly typical components of the emergence of traumatic memories. First, we can see the attempt to hold the memories at bay through symptoms—in Heidi's case, with alcohol abuse, drugs, and cutting. Second, because memory is so fragile, vulnerable, and fractured in trauma, the patient has trouble accepting the validity of his or her own experience. Did it really happen? Or am I just imagining it? This lack of grounding for the patient in the validity of his or her own experience is a slippery slope for both patient and therapist.

There is no easy answer here; some guidelines are essential. These are the ones I (J. R.) follow: Let the patient set the pace of the unfolding of the memories and put the traumatic experience in the context of the patient's larger history and narrative. As with Heidi, the very early onset of her symptoms, her split self states (hyperfunctional during the day; fragmented and vulnerable at night) pointed in the direction of early trauma. A patient's dreams and the transference relationship (George, at the beginning of this book) can also suggest early trauma. If and when memories start to emerge, it is essential for the therapist to believe how profoundly dysregulating and disorienting the experience is for the patient. The therapist must create a holding environment for the patient that often extends beyond the times of the actual sessions. And, finally, as bits and pieces of memories emerge, it is important for the therapist to keep in mind that the memories may never be retrieved completely and that full recall is not necessary. Heidi was able to recall the memories and create a plausible narrative for herself about her sexual trauma. The plausible narrative is essential, but the retrieval of full memory is not. Constructing a plausible narrative is sufficient to afford the patient the ability to integrate traumatic experiences into his or her life story.

Understanding the fear system facilitates clinical work with the whole range of anxiety disorders and trauma, as described above. As you familiarize yourself with how the fear system works, you will inevitably create a handful of (somewhat) standard ways of helping patients to "unpack" their own fear systems. For example, I often describe to patients how the self-reinforcing aspects of avoidant behavior can serve as a silent motivator for change. And, in panic disorder, I explain the brain physiology to patients as a runaway train, which helps them to participate in developing techniques that interfere with the escalating panic. These are just a few of my ways. As you the reader familiarize yourself with how the fear system works, other possibilities will inevitably present themselves. Possible approaches are likely unlimited.