Integrative Embodied-Relational Trauma Work

CPD Days in Oxford with Morit Heitzler

for counsellors and therapists working with trauma

suitable for practitioners from across all therapeutic approaches

22 September 2018
1 December 2018
2 February 2019

Are these workshops for me?

These workshops are designed for practising counsellors and therapists who are engaged in trauma work, and/or have some previous training or experience with trauma. If you have completed basic training in one of the modern trauma therapies: Somatic Trauma Therapy (Babette Rothschild), Somatic Experiencing (Peter Levine), Sensorimotor Therapy (Pat Ogden), EMDR, EFT etc, then you will definitely be eligible. Otherwise we ask you to contact us, to discuss whether the course will be suitable for you.

If you have trained and have been practising such trauma therapies for a while, you are likely to have encountered clients with varying degrees of receptivity, producing a mixture of results and creating a variety of problems. You may also have questions regarding the application of theory to practice.

Many of these problems and questions can usefully be addressed through an *integration* of trauma therapies, each of which have their special strengths and weaknesses.

These CPD workshops will support you in taking the next step and help you to deepen, diversify and enhance your existing practice. For the last 20 years Morit has been developing an integrative approach to trauma work that draws on most the various trauma approaches within an overall relational perspective. She will use her knowledge and experience in demonstrating and role-modeling an embodied-relational engagement with the challenges presented by the traumatised client.

Format of these workshops

These workshops will be oriented towards practice and provide opportunities for you to bring the problems and dilemmas of your actual clinical work. In the workshops you will find support, reflective practice, supervision, diverse new ideas and techniques from other approaches within a group of like-minded practitioners. Morit will provide a sequence of theoretical inputs, to help the group develop a shared language, especially regarding the relational complications you encounter with clients. Participants are invited to bring their particular questions and clinical issues to the group, and the theory will flow from that.

Previous participants have appreciated the mixture of theory, practice and experiential work of Morit's workshops. In these workshops, in addition to discussing relevant issues and challenges, Morit will suggest various experiential and observational exercises, that will help to bring clinical vignettes alive.

Do you experience these obstacles with your clients?

If some of your trauma clients show resistance, manifest stuckness or get caught in hidden dissociation or re-traumatisation dynamics, or you encounter unexpected ruptures, impasses or enactments, these workshops are for you.

If some of your trauma clients do not respond well or only very slowly to the kind of approach that you know works well with other clients, what are the factors that can account for these differences?

If some of your trauma clients are having negative reactions against you or the treatment, or you detect that an atmosphere of mistrust, shame or scepticism interferes with the work, how can we tackle these obstacles?

At the end of this document, you can find some background ideas for these workshops, covering the following questions:

- The relational subtleties underpinning the working alliance
- Why do we need an integration of trauma therapies?
- Are the new somatic trauma and energy therapies suitable for complex and developmental trauma?
- Integrating somatic-embodied and psychodynamic perspectives
- Treatment and the Relational Container
- The subjective and relational foundations of 'treatment'
- Vicarious traumatisation and the therapist's own bodymind

About the workshop facilitator Morit Heitzler:

Morit has been developing an integrative, embodied and relational approach to trauma therapy for the last 20 years. She began to encounter these issues in her practice long before they became widely apparent, and engaged with these dilemmas at the root of trauma therapy in a way which has helped her forge a robust integration. Over the years, she has given many presentations which address transference-countertransference dynamics in trauma work, and the dangers and transformative potential of destructive enactments. She is known for using her own body and embodiment as a resource in surviving such enactments and turning them into deeper understanding of her client's inner world as well as the therapeutic process. This perspective now underpins her supervision of trauma therapists and sheds light on common ruptures, stuckness and failures of treatment, especially cases of inadvertent re-traumatisation.

Dates, Times, Venue, Cost:

Dates:

Workshop 1: Sat. 22 September 2018
Workshop 2: Sat. 1 December 2018
Workshop 3: Sat. 2 February 2019

Venue:

OTS-Oxford Therapy Centre
1st Floor, 142-144 Oxford Road, Cowley,
Oxford OX4 2EA

Times:

10.00 - 17.00

Cost:

£100 per day

More information:

For all queries, contact:
Michael Soth +44 7929 208 217 or
michael.soth@gmail.com

Website: www.integra-cpd.co.uk

Dedicated page: http://integra-cpd.co.uk/cpd-workshops-events/integrative-trauma-therapy-cpd-workshops-in-oxford-with-morit-heitzler/

The relational subtleties underpinning the working alliance

Although many of these modern therapies claim to be comprehensive, often presenting themselves as applicable to *all* kinds of trauma, this is not what we find in practice. Human beings present complexities that no protocol or manual can legislate for, especially when it comes to the – often unconscious - internal web of trauma reactions and associations in the *psyche*. It is in these very individual responses to the therapy and to the therapist that complications arise which are not catered for by theory and technique.

The client reads – or mis-reads – the therapist's facial expressions, their speed, timing and intonation, their gestures and postures, and scans these for the warmth, professionalism, acceptance, knowledge or encouragement they might contain, or conversely for the coldness, lack of care, judgement, shame or impatience which the client may have come to expect from others.

It is the client's subliminal reading of such cues and messages which infuses the therapeutic interaction with relational dimensions that can make or break the treatment, but that are not necessarily part of the manual. It is these all-too-human subtleties which either provide a foundation for a productive working alliance, or create doubt and ambivalence, or lead to outright ruptures, regardless of how competent the practitioner, or how appropriate the treatment procedure in and of itself.

Why do we need an integration of trauma therapies?

Trauma therapies tend to fall into a few recogniseable categories along a spectrum of the therapist's relational position, in terms of they define themselves and their public presentation:

- some of the new trauma therapies define themselves as *treatments*, with clear protocols and procedures, administered by a knowledgeable expert; here the therapist is understood - by both parties - as an authoritative and directive doctor figure, requiring cooperation;
- in some other therapies the atmosphere is more oriented towards healing and recovery through the therapist's nurturing presence; here the therapist is positioned in a more motherly role, still an expert or an authority, but with an emphasis on feeling and support.

Because trauma makes us feel helpless and regressed, the therapist taking a motherly or fatherly re-parenting role can be very helpful and often this is necessary to establish a working alliance at all. However, developmental trauma makes any kind of re-parenting task more complicated, as the psychoanalytic tradition teaches us. Even in single event trauma, the internalised drama triangle of victim, persecutor, rescuer can become constellated in the therapy, and complicates what might otherwise be a more straightforward helping or healing relationship.

We cannot take it for granted that the client will experience the therapist's authority as benign. This has serious implications for the working alliance and for the success of the treatment. When the therapist's authoritative interventions and directions are received by the client through the lens of transferential complications, the methods and techniques of the various trauma therapies cannot be expected to work in the same way that in principle we know they can. Then the same techniques that we can usually so powerfully rely on are not sufficient to overcome stuckness, resistance, dissociation and avoidance.

It is then that a relational integration of different therapeutic approaches and perspectives becomes increasingly necessary and helpful. The different traditions and perspectives, and their different relational underpinnings, complement and cross-fertilise each other in a way which gives us as therapists more flexibility, robustness and resilience. This can make a big difference to the effectiveness of our work.

Are the new somatic trauma and energy therapies suitable for complex and developmental trauma?

Over recent years, the new somatic trauma therapies and the energy therapies have been extending their reach beyond clearly defined single-event trauma later in life to include early and developmental trauma. This extension has been driven forward on the assumption that the same principles apply to all trauma and to all trauma therapy. However, increasingly we find that this is a flawed assumption: it hinges on the question whether the client has a healthy, non-traumatised personality structure in the first place that will allow them to form a trusting attachment to a therapist. Without that bond, we cannot assume the client's readiness and willingness to receive the therapist's interventions, however competent and effective these are in principle.

In complex trauma, the issue of transference becomes unavoidable, as the client is likely to interact with the therapist *via* their traumatising early blueprint for relating. The client then perceives and experiences the therapist through the lens of that blueprint. This tends to complicate the working alliance and can undermine the therapeutic process in a way that is not sufficiently attended to in the recently developed trauma therapies. Therefore, early developmental trauma constitutes a qualitative difference to single-event trauma. Psychodynamic approaches have, of course, always appreciated the transference dimension, but have not worked sufficiently through the body.

Integrating somatic-embodied and psychodynamic perspectives

Therefore, an integration between somatic and embodied approaches on the one hand and psychodynamic perspectives on the other is becoming crucial in the field of trauma therapy. We increasingly understand how even clearly circumscribed single-event trauma can trigger early developmental trauma unconsciously and complicate and de-rail treatment, even when on the surface it appears fairly straightforward.

Psychodynamic and other 'talking therapy' practitioners can benefit from the somatic therapies in situations where clients' reflective capacities are limited, as language and other cognitive functions are impaired by unconscious or unspoken trauma. The client's mind is then not fully available for interpretation, collaborative exploration or associative play, as traumatic freezing and dissociation are dominant, and talking therapy doesn't reach deeply enough into the client's experience.

Treatment and the Relational Container

If as trauma therapists we can combine powerful methods and somatic techniques on the one hand and an awareness of the working alliance and the client's reaction *against* therapeutic authority on the other, our capacity to co-create the kind of relational container necessary for the work takes a quantum leap. To some extent this also depends on the therapist's awareness of their own body and embodiment, as the relational container depends strongly on 'right-brain-to-right-brain' attunement. This is only available to the therapist who is connected with her own subtle and subliminal physical and neurological responses.

In her practice Morit has found that the effectiveness of both EMDR and somatic trauma therapy interventions crucially depends on the *timing* of pre-reflexive communication, and the synchronisation between the client's and therapist's autonomous nervous systems. The difference between an intervention which elicits a relieving release of feeling on the one hand, or a suggestion which triggers in the client a re-traumatising implosion on the other may only be a couple of seconds.

The therapist wants to be so attuned to the intensifying arousal in the client's bodymind that they can offer an expressive and interactively regulating channel for it *before* it can tip into an internal roller coaster. Intervene too early, and the therapist is seen as anxious and over-controlling; on the other hand, intervene too late and the client's autonomic process has – lemming-like – taken itself over a cliff into a traumatic pattern. This kind of attunement is only possible if the therapist is sufficiently attuned to her own neurophysiological and vegetative processes that she can micro-track her own arousal and shut-down.

However, many therapists – especially when their initial training was in one of the 'talking therapies' - are too habitually disembodied themselves and remain largely unaware of the client's - and more so their own - subliminal and energetic processes to create that kind of moment-to-moment bond and responsiveness. As a result, treatments tend to lack spontaneity and significant moments are missed, giving the client a sense that they are indeed being 'treated', but in a somewhat formulaic fashion.

Fortunately, in Morit's experience, many therapists can learn quite quickly to extend their usual emotional sensitivities into the somatic and energetic realm.

The subjective and relational foundations of 'treatment'

However appropriate the theoretical models and practical techniques are that we use in trauma work, these are only as effective as the pre- and non-verbal bonds, the reciprocal emotional attunement and the mutual intersubjective understanding which the two human bodyminds in the therapeutic relationship can co-create. It's the meeting between these two idiosyncratic, unique subjectivities which – for better or for worse – provides the foundation for 'treatment'. By ignoring – or attempting to remove - the unpredictable subjective human factor from treatment, we destroy the essence of what makes therapy work. Of course, the therapist's identity is not free from its own wounds and traumas and shadow aspects – how can therapy be made to work when all we have at hand is the frail, imperfect instrument of the therapist's human self?

The therapist cannot be – in fact, for attunement and mutual identification to work: *must* not be – invulnerable, 'all sorted', plain clinically effective, administering the same uniform treatment to each client, whatever the manual says. However, the therapist's non-objective subjectivity does engender all kinds of relational vicissitudes which we need to find ways of apprehending: how do we monitor and bring awareness to the intersubjective mess co-created when the arrow of the client's wounding seeks and finds and hits the therapist's wounding?

It is here that differentiated bodymind awareness takes us beyond mental speculation into a realm of embodied experience where we have a whole realm of otherwise ignored and neglected information that makes the complex task of tracking 'right-brain-to-right-brain' attunement less impossible.

Vicarious traumatisation and the therapist's own bodymind

The recognition that trauma therapy is hazardous for the practitioner is now widely established, but it is much less clear what we can do about it.

Unlike medical practitioners who tend to learn to dissociate from their patients and the pain they encounter, we do not want to lose our relational sensitivity. But unless we can learn to recognise the symptoms, effects and emotional load of the therapeutic position, we cannot effectively process and digest the bodymind impact we experience through exposure to our clients' trauma. Understanding somatic resonance, projective identification and evacuation of dissociated trauma states helps us become aware of the consequences of unconscious processes in the therapeutic relationship, and the conflicts we are likely to absorb in our work.

Tracking and processing these unconscious dynamics, we gain precious insight into our client's inner world and their internal relationships, which provide the background context in which recovery and healing occur. This allows us to understand more deeply how current and past trauma interlink and generate protective mechanisms which block and slow down treatment.

Relational complications in trauma therapy

Journals Published 1 May 2018

Morit Heitzler and Michael Soth unpick the complex relational dynamics in working with victims of childhood trauma. Therapy Today, May 2018

Relational complications in current trauma therapy

or: why trauma therapy often isn't working as it 'should'

An article published in 'Therapy Today' in May 2018

Trauma therapy, aided by revolutionary neuroscientific understandings, has been very successful over the last 20 years or so, and has expanded enormously. New trauma therapies have proliferated, new tools, techniques and methodolgies have been developed, the reach and scope of treatable conditions has been extended and public and scientific acclaim (NICE guidelines) as well as financial success have followed (Ecker, 2012; Levine, 1997; Kalsched, 1996; Rothschild, 2000; Schore, 2003; van der Kolk, 1996).

Having extended their reach beyond the traditional focus on critical incident debriefing and single-event trauma, the modern trauma therapies, however, have reached a threshold. Increasingly, trauma therapists come into supervision distraught, frustrated and despirited because it is not working as it 'should'.

Supervisees report that clients who initially present with circumscribed single-event trauma either cannot or do not respond well to standard trauma techniques like finding a safe place, body scans, mindfulness, or learning techniques for self-soothing. Many clients, although apparently desperate, fail to cooperate or exhibit active resistance. Some push and test the boundaries of therapy (e.g. demanding contact in between sessions), question or criticise the therapist, and generally create an atmosphere of suspicion and mistrust. Or they just fail to get better in terms of the reduction of trauma symptoms.

In response to these unexpected problems, therapists report confusion or incompetence, shock or frustration, or - when more intense - feeling powerless, used or worthless. Occasionally therapists make sense of their response in terms of vicarious traumatisation.

About the authors:

This paper is a collaboration between **Morit Heitzler and Michael Soth** from our shared vantage point as supervisors.

Morit has been practising a variety of trauma therapies since the mid-1990s, integrating Babette Rothschild's Somatic Trauma Therapy, E.M.D.R, Sensorimotor Therapy, Somatic Experiencing, Trauma Constellations and various other trauma therapies.

Michael is known for integrating humanistic and psychoanalytic traditions to bring a more comprehensive embodied understanding to the relational vicissitudes of therapy (Soth 2005a).

Increasingly we find that our supervisees need help addressing the relational complications of what on the surface appears as fairly straightforward trauma treatment. We have been trying to find accessible formulations for these relational complications in a way which makes sense to therapists from across the diverse modalities. In this article we intend to share these with you, revolving primarily around the notion of the 'trauma quadrangle'.

Contact us for a PDF copy of the article.