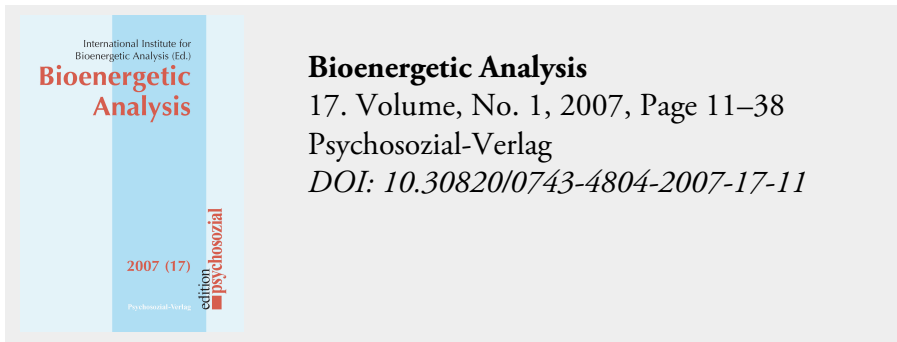


*David J. Finlay*

# Energetic Dimensions Of Trauma Treatment



Bibliographic information of Die Deutsche Nationalbibliothek (The German Library)  
The Deutsche Nationalbibliothek lists this publication in the Deutsche Nationalbibliografie;  
detailed bibliographic data are available at <http://dnb.d-nb.de>.

2007 Psychosozial-Verlag GmbH & Co. KG, Gießen, Germany  
[info@psychosozial-verlag.de](mailto:info@psychosozial-verlag.de)  
[www.psychosozial-verlag.de](http://www.psychosozial-verlag.de)



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Cover image: Theo van Doesburg: *Heroische Bewegung (Heroic Movement)*, 1916  
Draft design: Atelier Warminski, Bidingen

<https://doi.org/10.30820/0743-4804-2007-17>  
ISBN (PDF-E-Book) 978-3-8379-6887-3  
ISBN (Print) 978-3-89806-704-1  
ISSN (Online) 2747-8882 · ISSN (Print) 0743-4804

# Energetic Dimensions of Trauma Treatment

*David J. Finlay*

## Summary

I address both psyche and somatic dimensions of trauma treatment, emphasizing the key role of the client/therapist relationship. Somatic techniques are also emphasized.

**Key Words:** Energetics, Developmental and Shock Trauma, Embodiment, Metaphors, Vision, Processing

If trauma is the experience of the survivor most of the world lives in trauma producing environments. Those of us fortunate to have survival needs met live in proximate traumatic conditions. By this I mean that we are surrounded and inundated daily by traumas and while we might like to believe that these are events happening to others or some place elsewhere, this is little more than a manifestation of our disbelief system or numbing. The scope of traumas historically or from more recent events such as 9/11, Katrina, Iraq, Darfur, Lebanon or the murders just down the block, is alarmingly brought home to us each day by the world mass media. We are participants in these dramas whether willing or unwilling because they touch the lives of us all just as the threat of nuclear conflagrations have threatened our existence for years. They are also stressors which can activate seemingly unrelated traumas. Our recognition of the scope of trauma is relatively recent in terms of treatment and in some areas such as collective traumas, virtually non-existent except immediately after disasters and before social amnesia once again sets in. In this paper I attempt to bring closer together

psychic and somatic approaches to trauma treatment emphasizing the significance of the client/therapist relationship and embodiment – pieces of a larger picture.

## Background

Behind the cloak of science or any academic writing there usually is a biographical statement. Therapists often write about their own issues and I am no exception. I'll be brief but the biases and limitations in my paper need to be exposed. Trauma was my introduction to life. I was an unexpected and unwanted baby. According to the doctor who delivered me I came very close to death my first day because my umbilical cord came untied. My father saw my pallor, called for the doctor and I was given a direct transfusion even though my father and my blood types had not been established. For many years I had this strange question of not knowing who really gave birth to me, mother or father, or whether I even belonged. If my father saved my life then why did he absent himself in the years that followed except for being in charge of discipline where he was often very brutal such as whippings with a harness strap? His disinterest made me wonder why he saved me. I began then to create my own fantasy world of hope. Those were first traumas.

A second one was subtle and really not fully known until much later. Both my parents were essentially orphans. They knew little about secure attachment except as child administrators. I sensed their abandonment problems which I adopted as part of me. This was strengthened by the fact that there was no warm emotional life in our family and I learned early that expressions of feelings were not part of acceptability. We were poor and there was no room or time for extraneous things since work and survival were paramount issues on the farm in an economically depressed environment. There were also incidents of sexual molestation by an aunt but for many years I minimized them by simply thinking she was crazy. When I started school I was an »outsider« because four of my six first grade classmates always spoke German and came from an encapsulated Mennonite sect

with restrictive and authoritarian values. This »outsider insecurity« persisted no matter what my accomplishments.

So these were parts of my early years where vulnerability, insecurity and threat always seemed present. By age nine I was fully cognizant of my need to escape. Athletics (which my father thought a frivolous activity) seemed the best opportunity but physical injuries destroyed this dream and my adolescent sense of identity. Eventually academics became a realistic alternative. It is not surprising though that I chose political science as a major in college. Politics are about who gets what, when and how and I needed to know. Another illusion!

I did learn that traumas are passed from one generation to the next. The tragedies in my family eventually came out – a sister age 51 and a brother age 62 dying of heart attacks (broken hearts) and another brother of alcoholism. My father's »adaptation« was Alzheimer's disease and my mother committed suicide. As for me I will quote the assessment of a dear friend who knows me well and is a therapist: »I know that you are someone who has held trauma in your body for many years, has been a direct participant in some horrific experiences, chose not to share them with most people for many years, and have walked with some incredible suppressed but conscious memory networks for decades.« The major consequence of this behavior was denial of what I needed the most – intimacy, that which heals the heart wounds. I learned though, that I was not alone in this. What kept me moving was the relational »therapy« from mentors and friends (and some would add stubbornness). So now I am less afraid to see intimacy needs in myself or in others. In assessing trauma I know they are always there.

Originally I was drawn to the »promise of bioenergetics«, that if I really, really, REALLY got into my body, I would be »cured.« It was an illusion of course, because the underlying problem of dissociation was not seen or addressed. Yet, looking back, I also realize that my traumas were not easy to recover from because of the defensive edifices I had constructed which only led to further traumas. Awareness and healing take time.

Thus part of the biases in my paper are an emphasis on treatment of delayed onset trauma and my belief in deeper trauma processes than

some of the surface procedures being offered to trauma victims. While I address certain techniques I also believe that treatment is case specific – I do not believe in formulas although some can relieve or do reduce levels of distress. What this leaves out then are procedures using group and family therapy as well as the kinds of treatment offered by humanitarian agencies. I also must set aside problems of dealing with collective trauma, a great threat as we watch our fears being manipulated. I shall begin with brief statements about developmental trauma and shock trauma.

## Developmental and Shock Trauma

Developmental trauma usually results from inadequate nurturing, attachment and bonding during early childhood. Such traumas often occur, but certainly not exclusively, at a pre-verbal level where memories are often vague and inaccessible. The infant's first psychological task is to map out the personality contours (conscious and unconscious) of its caregivers, particularly to find sustaining channels of contact. When these needs are thwarted or entail abuse they create deficits or more pervasive and destructive organizing experiences around failed connections, relatedness and a sense of self which are carried over and seriously impair adult functioning.

Shock trauma is the result of an isolated event or series of events in which there is not necessarily any consistent history of previous trauma. It has been viewed as an inability to have a »normal« response (fight/flight) in »abnormal« circumstances, a definition which begs many questions.

As stated these typologies are rudimentary because developmental and shock trauma are often interwoven. However, shock responses are not gradual events of development. They are occurrences causing frozen immobilization or stimulating extreme activation of the nervous system. Both lead to chronic dysregulation in affect, learning, and behavior or Post Traumatic Stress Disorders (PTSD).

In both developmental and shock trauma there is an overwhelming of the person's capacity to cope or to integrate experience. Both effect

psyche and soma. There is unbearable psychic pain or anxiety, with concomitant somatization, that overwhelms the healthy self care system and appropriate defenses. At risk is dissolution of a coherent self, the destruction of the personal spirit. The ego at such times cannot provide an adequate defense and thus a second line of defense is formed to prevent the »unthinkable.« This can take many forms or has many different titles including dissociation, splitting, projective identification, trance states, psychic numbing, etc. They serve to preserve the life system of the person or to defend against annihilation. This »progressed« or dystonic part defends the regressed part against a repeat of that which is »unthinkable.« As D.W. Winnicott would put it, meaning is imposed on the mind-psyche or mind-object. Donald Kalsched states that »when other defenses fail, archetypal defenses will go to any lengths to protect the Self – even to the point of killing the host personality in which this personal spirit is housed (suicide).«

This dystonic or antagonistic part of the self-care system is a defense against further trauma but it also can become a resistance to all unguarded spontaneous expressions of the self in the world. And it can become »daimonic« making analysis almost impossible. In this sense it is like Freud's »death instinct,« Fairbairn's »internal saboteur,« Jung's »negative animus,« or simply the »bad object.« As an attacking figure it is similar to the actual perpetrator or events of trauma. As an ambivalent caretaker its function almost always seems to be the protection of the traumatized remainder of the personal spirit and its isolation from reality. Thus we have a Protector/Persecutor as an archetypal defense system. What is frightening is that this dynamic seems not educable i.e., it does not learn anything about realistic danger. All life then becomes a dangerous threat and is therefore attacked. Put another way, the traumatized psyche is self-traumatizing. Repetition compulsion is an inadequate explanation for it seems more like the self is possessed by a numinous diabolical power or malignant fate.

The inner world of the traumatized person is marked by a volatility in the gate-keeping of the self-care system. Affective systems become dysregulated often leading to a wide range of comorbidity disorders such as loss of impulse control. Homeostasis cannot operate or

achieve a balance between the »light« and the »dark.« This leads to a continuation of the trauma long after outer events or persecutory activity has stopped. The ego must be kept from feeling its own pain and symbolic integration cannot take place. Experience is rendered meaningless. It also leads to shame or a sense of being »bad,« »unworthy,« »worthless« or a composite self-destruct system. »Hope« is illusive. Conversely, however, sometimes opposites of such despair can arise such as megalomania, or delusions of superiority as a rigid defense against the trauma. Narcissistic disorders are a case in point.

»Indwelling« or an activating source or force must be established for the life spirit to grow and mature or to be resuscitated or re-born. Look at it from the point where the child is coming from: »If I cannot find Mother, I cannot psychologically organize myself, at least not in a reasonable or healthy way. I may organize a world devoid of humans, a world of imaginary relations, a world that is not real, or a world of fragmentation and madness.« What the person is saying given whatever trauma or abuse occurred is that »I'll never go there again.«

»Indwelling« in therapy means sustained interpersonal relatedness through reliable interpretative holding and touch. It is an empathic middle way between compassion and confrontation. The reality is that the dreaded breakdown or death *has already happened in the past*. If indwelling can get beyond the most destructive impulses of the organism and the mind, then there is the greater and terrifying fear of connecting or learning how to do it. The self does not forget at some organic level that, for example, »if I had been good enough, mother would have been whole and there, so she could mother me the way I needed.« Yet both the positive and negative parts of the self-care system exist simultaneously, even in their warfare over control. Can the therapist anticipate and be prepared to meet the client fully in all of these dimensions?<sup>1</sup>

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1 The sections on developmental trauma and shock trauma contain material directly from Kalsched, 1996, and Hedges, 1994.



## Protocols in Treatment

There are no agreed upon protocols in the treatment of trauma. Yet there are many partisans of particular treatment approaches, often without solid empirical support even though measuring outcomes would seem to be critical to their advocacy. Partisans generally *claim* success and while this may have a certain validity in given populations, the range of methodologies also suggests the infancy of our knowledge or our lack of certainty even though the antecedents of trauma studies go back further than Freud's early seminal works on the subject.

Among the various approaches current are Elizabeth Marcher's Bodydynamics, Francine Shapiro's EMDR, Milton Erickson's neurolinguistic programming and an off-shoot called visual/kinesthetic dissociation, Roger Callahan's Thought Field Therapy, Irving Janov's Primal Therapy, Stanley Graf's Holotropic Breath Work, William Emmerson's Birth Dynamics, Peter Levine's »naturalistic approach,« David Berceci's and Liz Koch's Trauma Releasing Exercises, reparenting, desensitization, flooding, hypnosis, various modes of group therapy and advocates of pharmacological solutions – just to mention a few! There are also a significant number of dubious approaches, particularly when pursued with evangelical zeal. More standardized treatments are suggested in DSM IV from the American Psychiatric Association.

It is not my purpose to review, compare, or even discuss these variations.<sup>2</sup> I simply want to present more of an epistemological approach that has often worked for me and I am not suggesting it as an alternative to those already mentioned. In fact, I have incorporated certain aspects of other people's frameworks, particularly Peter Levine.<sup>3</sup> His cautionary approach to treating trauma and restoration of the self resonates within me as a person and as a therapist.

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2 For a thorough discussion see: Bessel A. van der Kolk, et al.,(1996).

3 When I refer to the syntonic and dystonic sides of the self-care system I am referring in short-hand to Peter Levine's intricate concepts of the healing and trauma vortices (Levine, 1997).

## Cautions

There is, of course, a chicken and egg question: Where do you begin in the treatment of trauma? Wherever it is – *memory or narrative, the somatic felt self and contractions, feelings or catharsis* – you will have to begin twice over again. Unless a client is particularly able, willing and open to confront traumatic events, whether fully known and acknowledged or not, it is almost a tautology to state that beginning work is based on the establishment of trust, the recognition of empathy, a time frame of the present, and the ability of the therapist to suggest or find words that might express the client's anguished meanings. So often the question is not what the therapist *does* but who the therapist *is* in the complex and personal dyadic process. As Jacob Lindy alerts us, »the trauma becomes imbedded in the victim's schemata of self and others, and rarely remains as an isolated fragment« (van der Kolk, 1996, 530). These schemata will extend and include the therapist.

Thus the client's capacity to tolerate openness and intimacy and the therapist's ability appropriately to provide an environment of empathic response, are crucial to the success of trauma treatment. Knowing, being seen and heard, and recognizing the other are intrinsic or existential qualities beyond descriptive words. Call them resonance or soul identification if you will.

The process is often slow in unfolding, not for all people but certainly for many, particularly in delayed or late onset trauma. I suffered from alexithymia, an inability to find words for feelings. Often I would need significant time just to absorb that an-other was fully there. Sometimes my therapist, Jack McIntyre, would just quietly sit or make a physical contact while I tried to relate my experience, senses and affect. There were other times when I was fully assured that we were both there and Jack could use interventions. He recognized my deep holding, confusion and fear around contact. His empathic responses facilitated emotional release but more importantly they built a connection between us based on mutual love, trust and acceptance of differences. Robert Lewis defines this essence of a therapeutic approach in the following statement:

»When you have no words for your feelings, for what happened to you, for what is missing in you, we listen to the inner resonance – of your inchoate secrets – as it lives in your body. We help you sense and amplify this inner resonance until its movement comes close enough to the surface of your being to enter your consciousness. But we listen carefully to your words and we are touched by them when they come from the depth of your being that no one can put a hand on. We invite you to surrender to the spirit of your body and the body of your spirit – and in so doing, to embrace your true self« (Lewis, 1999, 109).

Traumas sometimes are very well disguised or sublimated, particularly when they are within bastilles of shame. When this is the case it takes considerable time, patience and intuition to find the »red thread« or denominator. For example, whenever Jack moved too fast with me, my accommodation was simply to give him what he asked for but sometimes it was not authentic. If he asked for anger I gave him anger, or tears or whatever. He soon spotted this pattern of accommodation and then would stop directions or questions until I could emerge real or not hide behind a false self. However Jack died before we completed our work and it took some time to sense, feel and then to own the very early traumas that had undermined my sense of self or indwelling. When the ingrained habit of sensing what the other wanted and adapting myself to that was broken it provoked a furious rage. I had lived by rules of accommodation and what that meant was a restrictive canon of fight or die. Accommodation was not flight. It was shame, low-grade depression and insecurity. With some resolution I sensed that something in my core essence had been missing or violated and it felt like *soul death*.

Finally, as already mentioned, another consideration is that the trauma you think you are dealing with may simply be a surface issue or a refraction of other and earlier traumas. This »tip of the iceberg« phenomenon is not unusual with trauma victims particular given the evidence around revictimization. I once contacted an agency of the Department of Veterans Affairs about a person who came to see me for one consultation after being released from a treatment facility for heroin use. I asked what evidence they had on Vietnam veterans staying clean. The answer was about one percent. The drug treatment had not

touched underlying traumas which went well beyond experiences in Vietnam and addiction. However the most pressing issue was that by going into a treatment facility, all of his »buddies« abandoned him for breaking a group norm of solidarity. He was alone just as he had been as a neglected child. He committed suicide.

So again we are back to the basic question of where to begin. Since traumas can so dramatically alter brain functions and personalities – from hysteria to absolute numbness – we often do not know exactly who or what we are dealing with or, by analogy, how wide, deep, and dangerous the iceberg might be. Freud's concept of »thought as experimental action« in a traumatized client is uncertain if not skewed or non-existent. Trauma can destroy any sense of personal agency such as resiliency or the ability to cope and manage stress.

Thus the first treatment frame is simply »who and where are you?« and »who am I with you?« I cannot assume I know what the trauma experience of a person might be, what they feel, how they view themselves or how they perceive events or me as a person and therapist. Thus I begin the work with the humility of a fellow traveler, not expertise or an inflated notion that I am the »guide«. This was dramatically brought home to me with a client I had worked with for over three years and we were approaching termination. She went on vacation to a Club Med facility and was brutally raped while a fish knife was held to her throat and repeatedly flashed at her eyes. This intelligent and competent adult (who was also a therapist) came back to therapy a frightened and paranoid child almost helpless. The trauma caused a total transformation. All reality was a threat and illusive to grasp including our history together. It felt like we were starting all over again with basic issues of trust and connection paramount. I had to discover her world anew. Parenthetically I might add that she had a very strong support system. This »environmental factor« is usually a key element in re-establishing a capacity for intimacy. It is a variable the therapist must always assess in treatment because it speaks to the crucial quality of healthy attachment patterns from the past and in the present. Such presence can strongly ameliorate the effects of trauma such as isolation and loneliness and enhance recovery.

With trauma cases the narrative may shift from one session to the

next. Memories may be uncertain or not stable. We also have to assess the balance, if any, between a person's healing and destructive gravitations. The healing self-care system must be re-discovered and opened otherwise the traumatized person is simply stuck in the trauma without safety or stability.

In somatic therapies such as bioenergetics there has been a tendency to emphasize techniques and formulas, initially in diagnoses (e.g., character) as well as to assess structure and functioning.<sup>4</sup> Thus the therapist watches closely patterns of respiration, metabolism and discharge of energy, emphasizing grounding and viewing such matters as determinates of personality and behavior. The unconscious is seen as conditioned by »energy factors«. Biologically energy can be measured but psychologically it is intuited and conceptually imprecise (Mahr, 2001, 117–133). Techniques do help identify »arrests« in development and they do expose the kinds of accommodations persons make in their own growth or lack of growth including character types. Techniques such as going over the breathing stool, stress positions or other mechanical means are, however, *secondary* in analysis and healing especially for the frozen and deep states of horror and dissociation traumas can produce. There have been, of course, »pioneers« in bioenergetic trauma treatment including Robert Lewis, Helen Resnick-Sannes, Michael Maley, Maryanna Eckberg, and others even though in the past the subject has not been systematically taught in training programs much to our detriment.

More psychic oriented therapies basically stress deconditioning through stabilization, education and identifying feelings through verbalization. The process involves a restructuring or reframing of personal schematas through symbolic representations such as »mindfulness«. Ego re-integration aims to release fight/flight responses and to restore healthy defense systems facilitating self-coherence and self-continuity.

I believe we know that these approaches are not antithetical and that treatment consists of their combination. Body and mind are in

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<sup>4</sup> See the various works of Alexander Lowen. Techniques are well described in Alexander Lowen and Leslie Lowen, (1977).

one sense synonymous and both contain their own forms of truth and lies. In trauma treatment both are of simultaneous and critical importance. However in what follows in this paper I emphasize physical dimensions of treatment and basically follow a Reichian format of segment ordering rather than the Lowenian approach where »grounding« through the legs and feet is emphasized. There is not one »correct« way of embodiment to connect with the earth or with reality.

Embodiment is vitality or aliveness, that which is ultimately destroyed by trauma. My suggested »epistemological« approach to trauma begins with words, then focuses on vision – our perceptual and conceptual apparatus – and then working with segments of the body from the ocular downwards. I conclude with some general comments about processing the content of the trauma experience.

## (1) Metaphors

In dealing with words or verbalizations and adhering to Bob Lewis' listening perspective, I start with the heart/mind connection because the heart is the most pulsating part of the mind/body nexus and the life it commands. Opening the trauma through metaphors usually avoids the overwhelming negative power and effects of direct confrontation of the trauma experience(s). Metaphors are simulacrum of conscious and unconscious reality and are an entry into *titrating* the trauma, i.e., letting it slowly emerge. To find the metaphors I have the client listen to his own heart with a stethoscope while lying down. Then the process is one of assessing their associations or at times guiding them into deeper descriptions or explanations. Questions in this process might be:

- What do you hear?
- What does your heart sound like?
- Do you like or dislike what you hear?
- Can you find a metaphor for what you are hearing? Describe the metaphor.

We begin to examine the metaphor, particularly as it is elaborated and what identification the person has with the images presented.

Often the initial picture related is a very mechanical-like reporting simply of a »thump, thump, thump« as though they were describing a machine. Yet with many who have never had such an experience there is also a certain wonderment and curiosity. There also may be expression of boredom and reassertion of ego control or dominance if too much vulnerability is felt.

Metaphors reflecting the heart are sometimes difficult to find particularly with people who have experienced traumas even though their other imagery may be quite vivid. It would seem some element of focus or possibly imagination has been curtailed and any scene, for example, may be arid. At that point I might ask »is there any life or aliveness there? Anything you can identify with or imagine?« Such questions normally elicit a response and the tack then is to find ways to elaborate whatever life, movement or pulsation exists in their description. This becomes the focus and is part of the healing impulses by which the trauma can be balanced and dealt with or alternatives formulated such as a place of rest or peace. All movement toward homeostasis becomes a point of reference.

Let me illustrate with a case. A young woman in a workshop was frozen in immobility and numbness and I could feel her terror. It took her some twelve minutes even to hear a faint heart beat and then the sound frightened her (just as she struck me as totally frightened of people and life itself). I never pushed, just let her listen. After thirty minutes I asked her about a metaphor and she said her heart sounded like a herd of galloping horses out of control. I then asked her to picture the horses and what they were doing. She said »they are galloping in a large meadow, galloping, galloping – NO, NO, NO, they are playing with each other. Oh God, they are PLAYING!« She began to sob deeply and her whole body began to shake caught between terror and excitement. I asked her if she could see herself as one of the horses and very shyly she said she could and wanted to. This went on for some time interrupted by giggles of delight. Gradually the gross vibrations settled into a gentle streaming through her body. An embodiment, grounding and perhaps healing had taken place, however

transitory it may have been. Later I found out that her frozen shyness was partially the result of very abusive treatment in a Catholic girl's school.

## (2) Vision

As »mirrors of the soul« I believe the eyes are key points for assessing trauma and for establishing the contact necessary for healing. We ground as much through our eyes as we do through having our feet planted solidly on the earth. The eyes inform the mind but they also reveal the secrets of the heart. *Vision involves the whole action system.* How one looks is as important as how one sees when dealing with complex visual and emotional tasks including deriving meaning from what is seen and experienced.<sup>5</sup> Eye language is more accurate than body language in how persons respond to information. Wolfgang Köhler summarized these processes as follows: »In the sensitive play of the eyes the inner direction, but also the difficulties, of a person become more easily apparent than elsewhere« (Köhler, 1957, 139). We do not necessarily see things as they are; we see them as we are. As projections the therapist is never an objective figure.

As with most trauma victims eye blocks always seem present whether in the fleeting movements associated with hyperarousal or the deadness resulting from numbness or dissociation. Contact raises the level of imagined threat as perceptions and belief systems may have been altered. Information (stimuli or sensory data) from the thalamus and mediated by the amygdala often is blocked from processing in the hippocampus, the cognitive map going to the pre-frontal cortex. Thus corrective information is distorted by the dominance of the trauma reliving in thoughts, feelings, images or actions. There are associated difficulties

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5 The assertive mode of visual functioning is looking, sending energy out through our eyes; the receptive mode is seeing, taking energy in. Our ability to look is a measure of how much we can assertively perceive energy and our ability to see measures our capacity to receptively contain energy.



with attention, distractibility and discrimination if not more serious problems of neurological changes which affect all learning.

There are numerous approaches, protocols and techniques for working with the eyes (and thus the »I«) perhaps the most thorough being Francine Shapiro's Eye Movement, Desensitization and Reprocessing (EMDR) (Shapiro, 1995). Ms. Shapiro has been very rigorous in demanding scientific research on the techniques and protocols involved in EMDR. Her »discovery,« however, is not new. Rhythmic multi-saccadic eye movements were used years ago by Reichians (Baker, 1967) and different versions of the same thing were developed by William Bates (Bates, 1940).

My concern is not who gets credit for what but rather that the eyes must be mobilized in all dimensions in the treatment of trauma and especially for the *healing relationship* to develop between therapist and client. The first »touch« between them is the eyes and if one or the other is blocked there, the contact is limited. The traumatized person needs to know that they are seen as well as heard. Robert Hilton put it more emphatically concerning his own personal therapy: »I needed someone who worked with the body, but more than that I needed a person who wanted to connect with me; not just a body, not just a problem, not just a character, not just an energetic system, but me, with all my weaknesses and needs« (Hilton, 2000). The importance of that *connection* is described by Paul Tillich: »We can discover our souls only through the mirror of those who look at us« (Tillich, 1962).

There are two separate but much related issues in eye work: (1) improving visual acuity including the ability to see and look in their psychological dimensions, and (2) focusing on trauma images consciously and unconsciously held and the feelings or emotions associated with them. As related as they may be I believe eye work should proceed in this order to avoid the possibilities of the client or the therapist being confused or even overwhelmed by problems in one dimension or the other. Assessing the cognitive map of seeing and looking which reflects how perceptions and beliefs are processed takes precedence. One reason for this is that eye contact has a positive impact on the retention and recall of information. Lack of contact can suggest just the opposite.

If Charles Kelley is correct, vision problems denote blocked pain, fear and anger (Kelley, 1971). Similarly David Boadella has proposed that vision difficulties have a direct relationship in the ability to have insight and outlook (Boadella, 1978). Certainly such problems may be simply the result of stress, genetic factors or an individual's personality or character structure but definitely they are associated with traumas.

## Mobilizing the Eyes and opening the Trauma

Wilhelm Reich viewed the body as having seven segments of armor, the first of which is the ocular. His description of the ocular segment has many parallels to those found in traumatized persons. »In the ocular segment we find a contraction and immobilization of all or most of the muscles of the eyeball, the lids, the forehead, the tear glands, etc. This is expressed in immobility of the forehead and the eyelids, empty expression of the eyes or protruding eyeballs, a mask-like expression of immobility on both sides of the nose. The eyes look out as from behind a rigid mask« (Reich, 1949, 371).

Opening or mobilizing the ocular segment too quickly as Reich (and also Alexander Lowen) tended to do by having the client simply open their eyes as wide as they could, can easily lead to retraumatization particularly where there are also early development deficits or where shame is a major factor. Why? According to one Reichian, David Shwenderman, »... for individuals with significant ocular armoring and accompanying psychopathology, there is no secure basis for exploring the world« (Schwenderman, 1988, 40–50). Shame induces a state of not wanting to see, be seen, or to look.<sup>6</sup> Thus it is advisable to

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6 O. Fenichel states: »I feel ashamed« means ›I do not want to be seen‹. Therefore persons who feel ashamed hide themselves or at least avert their faces. However, they also close their eyes and refuse to look. This is a kind of magical gesture, arising from the magical belief that anyone who does not look cannot be looked at« (Fenichel, 1945, 139). However, this view seems an over simplification of the impact of traumas such as rape. I believe Donald Nathanson, Michael Lewis and Michael Maley, among others, have greatly expanded our understanding of the impacts of shame in relation to trauma.

start with very simple exercises such as viewing themselves in a full length mirror. It is important in the beginning to have a sense of how they see themselves. For some traumatized persons no one is there (which is an indicator of their total lack of safety or security). The mirror work might also focus on what they see in their own eyes or how they project or mirror themselves in looking at the therapist's eyes.

Preliminary assessments might also consider left/right splits in the eyes. Some twenty years ago John Bellis argued that in the struggles against terror or horror they are »... *almost always manifested (when there is denial or disavowal) in a lateral (right-left) ocular split*. One eye reflects one set of feelings and attitudes, the other eye another« (Bellis, 1985, 156–167). This can be tested by having the client view through one eye and then the other. Usually the right eye would show the most hostility, distrust and reproach perhaps better locating or reflecting the extent of emotional damage. Bellis was also an advocate of the Reichian procedures of having the client follow a pen light (or finger) to mobilize the ocular segment. He also cautioned us by saying this may be slow work taking place over many sessions and warned »against therapeutic over-enthusiasm« in the use of any techniques for treating trauma. He was simply repeating the warning of Reich about the error of »*Too early* interpretation of the meaning of the symptoms or other manifestations of the deepest layers of the unconscious, particularly of symbols« (Reich, 1949, 371).

Opening the ocular bloc is enhanced by light finger touch on acupuncture or acupressure locations surrounding the eyes (or more precisely, points between the eyeball and the midpoint of the infra-orbital ridge). Acupuncture and acupressure points are sensory modulation techniques. In acupuncture the sites of insertion correspond to myofascial »trigger points« which, for example, inhibit pain reactions so often associated with somatization of trauma. More simply put, slight pressure on certain points relieves tension and reduces stress reactions and strain.

Corresponding to these procedures is work with the occipital-cervical muscles at the base of the skull. Pressure can be applied along the occipital ridge, again acupuncture points, and perhaps accompanied by blinking or movements of the eyes. David Berceci has pointed out

that »I have realized that the more attention I pay to my clients' necks, the faster they seem to be able to resolve their trauma issues, release the startle reflex, maintain an erect posture of their head and progress towards a healthy, integrated and grounded state in therapy« (Berceli, 1999, 14).

However, there is much more involved here than simple tension release, startle responses, postural correction or connections to the eyes. We often speak of the need for people »to get out of their heads« when, in fact, the need is for them to »own their heads« as a grounded part of their bodies rather than a »cerebral fortress« as Robert Lewis describes the anomaly. The traumatized or shocked person usually is dissociated from head and body with rigid defenses and thus the mind does not cease churning or obsessing. Lewis, reflecting the Reichian tradition, also suggests that »Deep work at the head end of the organism sets up a resonance in the diaphragm and pelvis. This is then an unsettling but powerful approach to opening the connection of self to heart and sexuality« (Lewis, 1998, 3).

At this point one might question »why all this preliminary stuff? What about the trauma?« The fact is that trauma gets stored in neural structures or neuron networks in our information processing system in the same form it entered. It is continually processed as a current event, not something that happened in the past (Shapiro, 1995, 40). New connections are not made. Eye movements, it is hypothesized, activate the information processing system to »metabolize« and to »assimilate« the trauma to »appropriate« levels of past and present time, particularly negative cognitions. These are then balanced or diffused with positive cognitions or healing images.

### (3) Extending Embodiment

However, eye work needs to be followed by further processes of embodiment because the effects of trauma are stored in the entire nervous system and organs of the body critical to functioning. Images and memories may not be readily available and must be teased out from their unconscious retention in both body and mind. Those who have

active images and memories can easily be retraumatized by moving directly or too quickly into catharsis or attempts to purge destructive thoughts and emotions. On the other hand, simple »body scans,« the sixth phase of EMDR procedures, are insufficient in the process of embodiment (Shapiro, 1995, 72–73). This is one of the shortcomings of a cognitive based approach to treating trauma.

Bessel van der Kolk has listed various psychobiological abnormalities in post traumatic stress disorders (van der Kolk, 1996, 214–241) and others already mentioned have assessed the need to keep the negative and positive aspects of trauma treatment in perspective. However, many arguments simply focus on what happens in the brain and its regulatory functions.<sup>7</sup> What is less clear is how trauma is related to emotional anatomy (except by inference). Stanley Keleman has pointed out that »feelings are the glue that holds us together, yet they are based on anatomy.« Anatomy he states is the »ground floor of brain programs, consciousness, the way we think and feel« (Keleman, 1985, xii). A person's »normal« physiology or character structure – whether in a state of hyperarousal or numbness, bounded or unbounded, collapsed or rigid, braced or compliant – is a further factor to be considered in the effects of trauma even though trauma and anatomy correlations may be uncertain.

Thus I would strongly contend that embodiment/disembodiment are central problems in trauma treatment. The »felt self« and »sensations« are only a partial approach to the problem. The purpose of embodiment, whether from conditions of trauma or not, is to restore vitality and integration, again and again. The »out of contact« state resulting from trauma demands »being in touch« but also »being touched« to find the way home again. This is where somatic based psychotherapies are crucial because they are based on fully experiencing oneself, one's own grounding, centeredness and personhood, beyond the limitation of words and information processing. Only in such a way can a person experience a »world« in which the self is located (Lifton, 1983a, 71–72).<sup>8</sup>

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7 The brainstem/hypothalamus, the limbic system and the neocortex.

8 Both »grounding« and »centering« are crucial aspects of restoration. While bio-

Understandably there are disagreements about the meaning, role and place of touch (Hedges et.al., 1997). Many psychoanalysts, for example, view trauma as a psychic phenomena whereas somatic psychotherapists see it as registered on a sensory-motor-affective level of the body (Lewis, 2000, 61–75). If touch is simply viewed as *resonance* there is a bridge between the differences but nevertheless questions remain about how that is expressed in the *alive* and *active* interactions between therapist and client.

I believe I have already declared my position by advocating »touch« utilizing acupressure points and their purpose. *Appropriate* touch allows us to respond to the world and for the world to reach those of us in our dark caves brought on by developmental or shock trauma. Trauma induces a state of emotional sensory deprivation as well as fear of contact, connection and intimacy. Feelings and sensations need expression but choices also must be available for their outlet including deepening the human contact between therapist and client. Therapeutic touch enhances movement between the sympathetic and parasympathetic nervous systems or, looked at another way, it also facilitates pendulation between the trauma and the healing impulses in the self-care system toward stimulating the recuperative process.

I began with Reich's first segment of armor and it seems logical to proceed with embodiment following his outline. This does not ignore the necessity to maintain grounding for the discharge of energy. The dissolution of the armor starts with regions farthest away from the

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energetics stresses grounding, the concept of centering has not been adequately elaborated. Lifton illustrates the psychosomatic and integrative functions of centering in the following words: »I understand it as the ordering of experience of the self along various dimensions that must be dealt with at any given moment – temporal, spatial, and emotional. On the temporal plane centering consists of bringing to bear upon the immediate encounter older images and forms in ways that can anticipate future encounters. On the spatial plane, centering means unifying (proximate) exposure, including bodily involvement, with »distant: (>ultimate,< »abstract', »immortalizing') meanings. A third aspect of centering is that of making discriminations in emotional valence between our most impassioned images and forms (what we call the »core« of the self) and those that are less impassioned and therefore more peripheral. The configuration which constitutes the psychic core is unique to each individual« (Lifton, 1983a, 71–72).

pelvis (i.e., ocular, oral, deep neck musculature, diaphragm, abdomen, and pelvis) (Reich, 1949, 370). The therapist *lets the body speak* and through that can assess what is happening in the autonomic nervous system and can conjecture about what else is happening in the brain.

Helen Resneck-Sannes and Sylvia Conant have summarized Peter Levine's procedures for working with the »four diaphragms«, a system essentially following Reich's hierarchy.<sup>9</sup> The goal is to open each segment but also to break the feedback loop activating a fight/flight/freeze response from the *locus coeruleus* in the brain stem (norepinephrine-containing neurons).

- 1) Have the client lie down with their legs out straight
- 2) Put gentle pressure on the triceps
- 3) Gentle support to the occipital ridge, pushing in and slowly releasing in order to give support
- 4) Hands over the ears, heels of hands on edge of eyes
- 5) Heals of hands on the clavicle – use hands in the same direction
- 6) Touch inside of elbows with thumbs
- 7) Hands on outside of diaphragm (slightly above), fingers pointing in the same direction
- 8) Palm of hand slightly above the pelvic bone or on hip bones
- 9) Back to the eyes – one hand in back of the head and one hand in the middle of the forehead
- 10) Very light touch on closed eyelids
- 11) Return to the neck with slightly more pressure
  - a. When working with infantile anxiety, hand on neck and one on lower back
- 12) Touch in the middle of the diaphragm
- 13) Gently massage the viscera

These simple techniques are designed to relax the body and allow sensations to flow which are correctives to the numbness or hyperarousal brought on by trauma. However a word of caution is necessary. It is important that the therapist fully evaluates his own empathetic re-

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9 Personal communications.

sponse and resonance with the person. A traumatized person is often hyper-vigilant. He will read your touch as well as you might read reactions in his body and will spot phoniness immediately. If signs of distress occur, stop the process.

In these exercises talking should be kept to a minimum as it may simply trigger reactions from the sympathetic nervous system which increase arousal but not necessarily awareness. Debriefing is essential in terms of whatever thoughts or images occurred for they will provide a wealth of material around the ways in which the trauma(s) are being dealt with and the stage of the therapeutic process. The bridges built in the preceding procedures allow deeper openings into the images and memories of trauma *if* they have established safety and security – prerequisites for recovery.

However the process of embodiment is far from complete. Body tensions and contractions produced by trauma are often rigidly held and release is not a matter of will or evolution. They have their parallel in gate keeping functions for protection against greater pain but in so doing they hold the existing pain. Among somatic therapists there seems agreement that such tensions, contractions and the feelings associated with them must be released for resolution to occur. There is, however, no agreement as to the best way this should be done and there is inadequate evidence to back most claims of success.

For example, among Reichians there is often reliance on »paradoxical breathing« to charge and discharge the held body patterns. Bioenergetic therapists traditionally emphasize the same charge-discharge-relaxation model but also work with innumerable techniques for release such as inducing deep crying, holding stress positions until surrender and more vigorous activities such as kicking, hitting and shouting. Both agree that the negativity and pain held in the body must be confronted by one means or another. On the other hand, »Energy Psychologists« (Thought Field Therapy) contend that with mechanical like »tapping« on acupuncture points or meridians, joined by humming and/or eye movements, trauma can be »cured« in an amazingly short time (Bray, 2006, 103–123). There are many other illustrations of divergence and contentiousness.

However I believe the psoas release exercises of Liz Koch are



useful adjuncts given the preceding work described. They now have been translated as trauma treatment largely by David Berceli although, in my opinion, with an exaggeration or theoretical reification of the functions of the psoas muscle (Koch, 1997; Koch and Berceli, 2005).<sup>10</sup> It is claimed that through a series of positions producing »shaking« (or what is usually called »vibrations«), the body finds an inherent corrective or self-recovery process from trauma.<sup>11</sup> Despite an uncertain validity I find these exercises helpful. Opening the four diaphragms is insufficient in connecting the lumbar spine to the legs and the Koch/Berceli exercises are appropriate in that regard as well as releasing tension in the lower back and pelvis. Sometimes simply correcting posture or testing the hip for range of motion can be just as effective in dealing with the iliopsoas and referred pain. Tomography tests give clearer diagnoses of impaired functioning.

At this point in the embodiment process it is necessary to ping-pong between the segments and to work homologous structures such as the jaw and the pelvis. This evens and balances energy in the system and thus facilitates wholeness and unity. It also disrupts the defensive equilibrium, i.e., people will tighten in one part of the body as others are loosened so that you work back and forth between under and over-charged areas. This will affect the overall tonus of the body. Just as a certain tension is necessary for the body to retain structure, so also is discharge.

Such embodiment opens healing avenues in the body toward a self grounded and present in the realities of sexuality and personal bonds, learning and doing, home and place, playing and working, transcendence and death. These are images and symbols of our psychic core endangered by trauma (Lifton, 1983a, 72). Until that core or indwelling is re-established in both body and mind, the seeds from trauma can always germinate if not explode unexpectedly.

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10 For a thorough view of the psoas and adjoining muscles and their functions see Travall and Simmons, 1992, Vol. II, 89–109.

11 For a related questioning of this assumption see: (Lewis, 1999).

## (4) Processing the Trauma

My purposes have concentrated on (1) certain somatic interactions between client and therapist and (2), bringing the person into the treatment process in present time. The elaboration about certain techniques has been somewhat secondary. In both dimensions there will be a continuous telling of the narrative but I have not dealt with that. It is simply an assumption on my part.

However, in questions about processing the content of the trauma, once again we are in a field of controversy among practitioners. I believe there is general agreement that the trauma must be *desensitized and defused* from the energetic charge it holds with such deleterious effects. Historical experiences must be differentiated from today's reality so that the person might live in present time without flashbacks and the like. I think therapists of all schools possibly could agree that key elements in happiness and well-being diminished or destroyed by trauma are (1) vitality, (2) curiosity and interest in the immediate world, (3) hope and optimism, (4) gratitude, and (5) the capacity to love and be loved. It is out of such factors that a healthy self-regulation exists with corresponding mental health, self esteem, positive emotions, and greater self-motivation. To me restoring vitality is a key point but a topic for another paper.

Where variations in treatment exist is in the preferred ways to facilitate the processing of trauma. A general review of approaching trauma has been suggested by Bessel van der Kolk, Alexander McFarlane and Onno van der Hart and articles in the same source speak to different aspects or schools of thought about trauma treatment (van der Kolk et. al., 1996, 417–440). Likewise the role of catharsis presents a continuing debate as Angela Klopstech has described so well (Klopstech, 2005, 101–131). The possible roles of the therapist are also contentious (Stark, 1999). There is no need to repeat all of these arguments here. While our knowledge increases we are still touching different parts of the elephant without knowing the whole.

One of the early themes in trauma treatment was the idea that the client must remember, re-live or re-experience the trauma in order to decrease the charge, put it into history and alleviate on-going symp-

toms. Sometimes desensitization processes such as »flooding« accomplish this and sometimes they lead simply to reactivation. They can also imprison both therapist and client in an endless repetition of the raw material and nuances in the narrative, or a continual search for memories and answers to »why?« questions.

Michael Maley has written that in both trauma and shame there is a breakdown of pulsations in the body and psyche and that a person can be trapped at the negative end of fundamental dualities – dualities which are part of normal development and without which development, growth and change cannot proceed. He illustrates this with concepts from Robert Jay Lifton concerning pulsations between connection and separation, integrity and disintegration, movement and stasis. In trauma separation, disintegration and stasis predominate and movement is lost. Maley emphasizes that »the duality of integration-disintegration can be restored through the mechanism that we all know about – *connection*« (Maley, 2006, 60; emphasis added). This parallels Peter Levine's ideas of developing resources that release the trauma charge without sending the person into retraumatization.

Theoretically this is fine but problems of implementation can be difficult. Let me illustrate with a brief description of a case. Some 30 years ago I saw a client for two years – a young man who as a child had been abandoned and by the time he was ten years old had been moved through five different foster homes. He had been incredibly brutalized including beatings, rapes, imprisonment, admonishment daily about his sinful nature by religious fanatics, and the like. My goal at that time was simply to help him stabilize his existence and I thought parts of that had been established. About two years ago he came back into therapy in a suicidal and homicidal state and to my utter horror it was exactly the same place as the first day of our previous work together. After I processed my »failure« what I slowly realized was that he had no sense of dualities (they were just words, perhaps to me as well). His only orienting belief was brutality – toward himself, toward others, toward all life. Thus I found myself focusing on re-education centering on compassion. Without such knowledge of another pole he had no means to evaluate experience other than trauma and no way to assess his feelings and their somatic states, let

alone establish secure social connections and interpersonal efficacy. Indwelling was never really established or, possibly, what might have been there was totally overwhelmed and lost. Fortunately I got him to enter Alcoholics Anonymous and he then joined a Christian living community and those alternatives and connections more than therapy gave him a structure and meaning which defused the tyranny of the past and saved his life.

Traumas always seem to carry with them a sense of loss and, if so, treatment processes have their parallels in the generalized stages of confronting death as enunciated by Elizabeth Kübler-Ross – denial, anger, bargaining, depression and acceptance. »These are the scenarios of loss«, according to Stephan Levine. »They are the stages of converting our predicament from tragedy to grace, from confusion to insight and wisdom, from agitation to clarity« (S. Levine, 1982, 233–234).<sup>12</sup>

Whatever the processes of debriefing or diffusion I believe there is a general rule that for client and therapist alike, *awareness precedes intervention just as understanding needs to precede interpretation*. We must go well beyond survival or coping as goals. If this occurs, then I believe there is the possibility of turning the horror, shame and guilt accompanying traumas into realities of change, into animation rather than stasis, into renewal and vitality. The daimonic becomes a memory not an active agent.

I have discussed two polarities in trauma treatment – those who primarily use a somatic approach and those who deal with trauma as a relational psychic phenomena. I did so because of my own experience at an earlier time when a more integrated approach rarely existed. Now I believe such integration is *slowly* developing but our »schools« whether in psychiatry, psychodynamics or various somatic approaches still lag and still seem rather entrapped by shibboleths and orthodoxies. Healing for me never came from a school of thought, an approach, a technique, etc. It was a relational somatic process that came through the empathic wisdom and humility of the therapist.

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12 A more »classical« interpretation of trauma treatment processing is in the excellent book of Maryanna Eckberg (Eckberg, 2000).

That was my experience with Carl Rogers and Jack McIntyre, different but gifted men with enormous hearts and vision.

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## About the Author

David J. Finlay is an International Trainer and has coordinated training programs in Europe, New Zealand and the United States. He has been a member of the IIBA Executive Committee and the Board of Trustees. Among his publications are *Enemies in Politics* and *International Relations on the Planet Earth*.

4231 Lemon Street, N.E.  
Salem, Oregon  
97305  
Email: [djfinla@attglobal.net](mailto:djfinla@attglobal.net)