THE WORK OF STABILIZATION IN TRAUMA TREATMENT

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Although most therapists have by now heard the message that trauma treatment must begin with an emphasis on safety and stabilization, it is often very difficult to know exactly **how** to help the trauma patient stabilize. As clinicians, we can easily get so caught up in the roller coaster ride of crises, suicide attempts, hospitalizations, drug and alcohol relapses, and self-destructive acting-out that we ourselves start to feel out of control! I believe that those frequent experiences of joining the patient on this roller coaster ride, rather than helping them get off it, happen because our training encourages a more passive role than is appropriate at the stabilization phase of treatment. Empathic listening, encouraging the patient to take the lead, and careful attention to the patient's feelings and experience can actually be counterproductive at this stage of therapy.

Such a statement, of course, stands in contradiction to the training received by the vast majority of clinicians: how could empathic listening be wrong? how could attention to the patient's feelings ever be counterproductive? how could we think of discouraging the patient from taking the lead?

However, if we are listening empathically to the patient's account of a flashback or nightmare, for example, we may be making her intrusive symptoms worse. If we are passive and sympathetic while the patient recounts the week's events which led to her cutting episode, then we may be colluding with her belief that stressful daily events are beyond her capacity to handle and can only be dealt with using extreme measures. If we do not actively label as symptoms the patient's self-loathing, self-destructive impulses, anxiety, hypervigilance, and difficulties with self-regulation, then we may foster the impression that those symptoms are characteristics of the patient rather than features of a trauma-related disorder.

The work of stabilization, then, begins with a change on the therapist's end: a change in attitude and a change in role. The therapist must first adopt the attitude that nothing, not even the patient's feelings, is more important than safety and stability. The therapist must believe strongly that recovery from traumatic experience cannot take place without sufficient stability to be able to remember the past without becoming overwhelmed by it and thus re-traumatized. Next, the therapist must assume the role of teacher or guide to the patient. Trauma survivors cannot teach themselves how to be safe and stable because they have no baseline, no meaningful experience of what the words "safe " or "stable" mean. They desperately need a teacher: someone who will provide structures for

learning, a wealth of information, and feedback. Traditional psychodynamic training discourages us from providing structure and feedback, but, at this stage of the work, we must find ways to overcome our training for the sake of the patient. A trauma survivor can have a meaningful, productive life without ever remembering or processing the trauma, but she cannot have such a life without doing the work of stabilization. The message for the patient is a simple one: no recovery from trauma is possible without attending to issues of safety, care for the self, reparative connections to other human beings, and a renewed faith in the universe. The therapist's job is not just to be a witness to this process but to teach the patient **how**.

As with any teaching paradigm, the therapist needs educational models and tools. For stabilization work, the most important tools are: psychoeducation, therapist modeling of attention to safety, skill-building, and empowering the patient by teaching her how to take charge of the therapeutic process.

The use of psychoeducation has two purposes at this stage of treatment:

(1) it teaches the patient about the symptoms: how to recognize them, how to anticipate them, what they mean, how to manage them; and
(2) it decreases the patient's shame, confusion, and sense of being crazy, especially if we offer the psychoeducational input in empathic and empowering language.

The importance of decreasing shame at this stage of therapy cannot be emphasized enough. A significant factor in stabilization is the gradual re-defining of the patient's role from that of victim to that of survivor. We want to teach the patient about trauma and PTSD in ways that celebrate and emphasize that, if she had the ability as a small child to survive these terrible experiences, then she has all the resources she needs to recover from the symptoms of those experiences. We want to convey to her that all of these symptoms make perfect sense as a response to traumatic experiences. Each represents either a deeply encoded memory or an attempt to solve a challenge or danger she faced as a child. Each was an ingenious solution to an overwhelming environment, and they worked, or she would not be sitting with you now. This approach not only de-shames the survivor; it is also empowering because it draws the picture of someone who is smart, creative, resourceful, and more in control of her destiny than she feels. Each and every troubling symptom can be re-framed with the appropriate psychoeducational input. For example, suicidal impulses can be re-interpreted as an attempt to cope with feeling trapped, helpless, and out of control in the face of overwhelming affects or as "feeling memories" of wanting to die or fearing annihilation in the midst of a traumatic experience. Cutting or other types of self-injury provide opportunities for psychoeducation about psychobiological effects of trauma: how the sight of blood or the physical pain of injury can trigger an adrenaline response which produces a calming and alerting effect. While acknowledging that these short-term methods of coping have long-term negative consequences, a psychoeducational approach discourages shame and self-blame and encourages the development of other coping strategies for solving the same symptomatic problem. For example: hypervigilance becomes "you learned to stand

guard over yourself because no one was there to protect you"; sexual acting out becomes "you learned how to have power over men as they previously had had power over you"; mistrust and paranoia become "you learned that it was safer to assume the worst in people than to assume the best"; self-loathing becomes "you found a way to protect your family [or to feel you had some control] by blaming yourself."

The other key message in the psychoeducational piece of stabilization work is that **the trauma survivor has symptoms instead of memories**. It is extremely helpful for patients to understand that many of their symptoms are memory equivalents. For example, anxiety and panic symptoms are almost invariably "feeling flashbacks" triggered by a relatively benign event in the here-and-now, such as being alone in a room at twilight. If the patient could remember the trauma the way we remember non-traumatic events, she could say to herself, "I hate this time of day because it reminds me that, once darkness fell, I had to start dreading what might happen to me later that night." Because memories of trauma are encoded sensorially, not linguistically, the patient relives the dread as inexplicable generalized anxiety or even as a panic attack. If we teach her that those symptoms are her memories, we can help her to develop a greater sense of control over them and help her add another piece to her personal narrative, such as, "It's amazing: I was that afraid every day, and I still managed to go to school and get all A's and come home and help my mother with the younger children."

During the stabilization phase, any and all kinds of psychoeducational input is useful because it helps the patient to make sense of her overwhelming feelings and behavior. I often go over the DSM-IV diagnostic criteria for PTSD with patients so that they can see for themselves how I have concluded that they are not crazy, just traumatized. Developmental psychology concepts, such as the concept that children internalize the healthy soothing they receive so that it becomes self-soothing, can provide a way to introduce self-care techniques. We can help the patient to normalize the feelings she has pathologized, such as mistrust, or, conversely, to appropriately label as "symptoms" the feelings she may have experienced as "normal," for example, her self-loathing. If the therapist is a teacher, then, like any good teacher, he or she brings in whatever information the student may need at this stage of learning.

In addition, the teacher/therapist also performs an important modeling function. Modeling should ideally begin at the very first contact with the patient, whether over the phone or face-to-face. Modeling has two purposes: it indirectly teaches the patient new skills and it directly offers the patient an experience of protection and safety which he or she may never before have had. What we want to model is our constant concern and interest in safety and self-care. So, for example, in an initial phone contact with a new patient, modeling might consist of asking the patient whether she has ways to keep herself safe or to make sure she has support between now and her appointment. Already the therapist is expressing a concern for safety and an attitude that safety is an important part of therapy. Modeling continues when the patient is undergoing the initial evaluation, too. Concern should always be expressed about the consequences of going over a trauma history, and there should be some discussion at the end of the interview about whether

the patient is feeling more overwhelmed and unsafe and what to do about it. For example, I usually preface inquiries about trauma and family history by saying, "When abuse survivors try to tell someone what happened to them, they often start to re-live it. Does that ever happen to you? I don't want you to have to leave here overwhelmed, so please let me know if you are having a lot of distress, or stop and take a break and we'll talk about other things for a while." If I notice that the patient seems to be experiencing a lot of distress, I will interrupt her and say, "Do you want to stop and take a deep breath? We don't want this evaluation to make things worse for you, so let's take it slowly." Even if the patient is not exhibiting distress, I may stop and ask, "How are you doing with this? Is it OK to keep going?" If an unstable patient, even a long-term one, reports nightmares or flashbacks, I never ask what they contain. If the patient volunteers the information, I ask, "Is it safe for you to talk about this? What will happen if you do? Will you feel better or worse?" If she does not volunteer details, I may express my willingness to hear them if she wants coupled with my concern that talking about them could cause her to re-live them.

The question is always, "If you do this [talk about it, tell your boy friend off, disclose the abuse, act out, ask for help, avoid asking for help], will you feel better or worse?" Notice that this approach combines psychoeducation about PTSD and its effects along with modeling a way to self-monitor her symptoms and prevent inadvertently exacerbating them, either in a therapy session or in the context of her daily life.

If the patient wants to talk about her memories but has a past history of de-stabilizing in the context of doing so, then I will even go so far as to say, "You may want to talk about your memories, but it isn't safe for you, and I would be remiss if I allowed you to do something that would put you at risk. I can't stop you from hurting yourself outside of this office, but I can stop you here." If the patient accuses me of not caring about her or what happened to her, I will say, "I am just as eager to hear your memories as you are to share them, but I cannot be self-centered and encourage you to share things with me when I know the price you will pay later on." Similarly, if a patient has been acting out self-destructively yet wants to talk about how uncaring her family is, I will insist that, as much as I deplore her family's inability to support her, we have to talk about her safety first. Or if a patient has been isolating herself and not going to work or appointments, that will be the focus of my interest because this lack of active involvement in the here-and-now will put her at risk for increased PTSD symptoms. I will embed all of these interventions in a context of psychoeducation: I will explain that, the more she isolates, the more she will psychologically re-create the environment of her childhood and, in so doing, increase the likelihood of triggering intrusive memories; that she has difficulty protecting or even valuing the safety of her body and mind because she has been deprived of experiences of care and protection.

As you can see, the work of modeling has the added therapeutic value of bringing the safety and stabilization work into the transference. And like any work with transference, the patient may not always like it and may need to express anger or displeasure when the therapist insists on "safety first" even in the therapeutic hour. I think of it as kind of therapeutic "tough love" stance: it is a more caring act to insist on stabilization in the

therapy hour than to allow the patient to act in ultimately self-destructive ways.

With enough modeling and enough psychoeducation, even the patients most strongly wedded to their trauma symptoms will begin to be ready to learn stabilization skills. Their readiness will have developed as the teacher/therapist has repeatedly challenged their view of themselves and their symptoms through modeling and psychoeducation. The skills needed by trauma patients in order to stay stable include the following:

- · grounding and centering techniques
- · coping strategies for dealing with suicidal and self-abusive impulses
- · contracting for safety with themselves and others
- · how to anticipate stressful or triggering events
- · learning how to calm the body and mind
- · distinguishing past and present reality and how to stay "in the present"
- · recognizing and making better use of dissociative abilities

Grounding and centering.

This is a set of skills for use whenever a patient is feeling any level of distress, particularly when she is overwhelmed or dissociating or experiencing escalating anxiety. "Grounding" refers to the ability to have not only our "feet on the ground" but our "minds on the ground." Usually I start by asking the patient to take a deep breath or to sigh! Then I explain that I don't want her to become overwhelmed by [whatever we are talking about], so we are going to stop and get her re-grounded first. I suggest that she change her position and try to notice the feeling of her feet on the ground and the chair under her, or to look around the room and see what looks like familiar ground in the room. Although grounding literally relies on having a connection to the ground, it can be helpful to cover several senses: what tactile or kinesthetic sensations help her to feel more grounded? What visual or auditory stimuli help her to feel more present in her body? More centered? We may use one of the many objects in my office to see which, if any, are grounding: a Slinky, a Nerf ball, a stress ball, worry beads, Silly Putty or Play Dough. I explain that touching cold objects like stones or even ice cubes can be grounding and that smell is a powerful sense for grounding purposes if she can find smells that are very strongly linked to the present, such as coffee or tea or rubbing alcohol or a fragrance. The kinesthetic experience of walking or washing dishes or ironing can also be grounding, as can focusing activities like jigsaw or crossword puzzles or knitting. Playful activities can be grounding, so can cooking or gardening. All of us need activities in our lives that help us to stay centered and grounded and present in our bodies, but for trauma survivors, these abilities help to combat the post-traumatic cycle of somatic and affective intrusions alternating with avoidance and numbing.

Often, patients with significant dissociative symptoms are so used to the experience of being not present in their bodies that they must be taught how to notice the degree to which they are more or less grounded. I begin by asking them, "How fully present in your body do you feel right now? What percent? 50%? 20%? 75%? Notice that I begin

with an acknowledgement that it is highly unlikely that they are fully present so that I do not trigger their shame and sense of defectiveness. Sometimes a patient may need an explanation of what that means, but most trauma survivors are so familiar with varying degrees of "not present-ness" that they are reassured by this type of discussion. Having established a percent, then the therapist and patient can experiment with how to increase the degree to which she can come more fully into her body: does it help to use one of the sensory modalities described above? Does it help to get up and move around the office or change seats? Does it help to breathe into her body? Does it help to talk about the weather or her pets or her children or her apartment or the latest book she has read? Does it help to do something more concrete and less cerebral than talking? (For example, I keep an easel with a pad of paper and markers in my office so that either the patient or I can develop diagrams, make lists, write down goals or schedules, or draw. These activities are often extremely useful for grounding because they draw the patient's focus away from the intense affect or put the affect into verbal, intellectual format which is less overwhelming.) A caveat: therapy sessions are rarely useful if the patient is less than 60% present in their bodies. Not only will the patient get very little out of sessions in which they are not present, there is also a greater likelihood of the patient getting inadvertently triggered without therapist or patient realizing what is happening.

Coping strategies for dealing with suicidal and self-destructive impulses.

Assuming that the stage has been set in the early weeks of therapy through both modeling and psycheducation, therapist and patient are ready to undertake the work of stabilizing the most unsafe of the patient's repertoire of survival strategies. This work begins with the development of Safety Nets. Concretely, what is the patient going to do in the face of these powerful impulses other than acting on them? I offer the safety net metaphor from the circus: the high-wire circus performer has more than one safety net. She has two or three nets under her and a safety wire around her because what she is attempting to do is very, very dangerous. Similarly, the recovery process is dangerous for the trauma survivor because the pain of remembering the past can threaten her survival all over again. Using this metaphor, we can help the patient to develop 3 or 4 levels of "safety net", one for anticipating stressors or triggers of unsafe impulses, one for self-destructive thoughts and mild impulses, another for intense impulsivity, and one for out-of-control impulsivity which almost invariably includes going to the emergency room or hospital. This differentiating of feeling or longing from impulse and from intentional action is crucial to working with trauma patients: suicidal ideation or longing is a common symptom-memory of trauma. If therapists respond to ideation or wishes as if they were dangerous actions, we can inadvertently exacerbate the patient's suicidality. If we differentiate the normal longing for the pain to be over from impulsive behavior or even intentional behavior, then the ideation is less likely to intensify to the level of threat. [A caveat: never agree to include "calling the therapist" under the first or second safety net because it will encourage over-reliance on the therapist when the goal is to increase the patient's resources and sense of mastery. If you wish, it can be included as part of safety nets 3 or 4.] Using the Safety Net approach, the patient might develop a hierarchy of coping strategies as in the following example:

Safety Net 1: Read trigger list at beginning and end of day to anticipate potential triggering and overwhelm
Read therapist's Coping Reminder card
Stay active during periods of feeling vulnerable or overwhelmed: engage in activities that keep you connected to the here-and-now

Safety Net 2: Do grounding activities: take a walk, wash the dishes, do jigsaw puzzle, take another walk
Go over list of coping strategies for unsafe thoughts
Try to stay connected to the present and to other people

Safety Net 3: Do not be alone (have someone come over or stay on phone until feeling less impulsive)
Use survival kit to help manage impulses (see below)
Leave message on therapist's machine
Read over list of Intentions (what you will do and won't do)

Safety Net 4: Call therapist
Go to ER

Another coping device is the development of a survival kit. The patient is asked to assemble a collection of objects which can ensure her survival no matter how unsafe she feels. The therapist explains that it is important to put together a survival kit before she feels unsafe because she will have lost her ability to think clearly by the time she needs to use it. A survival kit might include a card or note written by the therapist, an affirmation, a list of things she could do to keep herself safe, a photograph of someone or something to live for, a talisman, a transitional object like a stuffed animal, a list of people to call, letters of love and support from her friends, or even a list of reasons to live no matter how much she wants to die. The therapist's responsibility does not end with the request to the patient to assemble the survival kit. For this technique to work, it requires that the therapist periodically check to see whether the survival kit is in place and whether it is adequate to the immense task of helping to combat post-traumatic self-destructiveness. If the patient acts out unsafe impulses, it is imperative that the therapist inquire about whether and how she used the survival kit and encourage continuing efforts to improve it if it is not sufficiently containing.

A third useful strategy for coping with unsafe behavior involves the creation of a Safety Thermometer. This strategy has the additional benefit of requiring extensive discussion of the patient's affective states and how she copes with them. First, patient and therapist develop a 1-to-10 scale to measure unsafe feelings, with 10 being suicidal and ready to act without hesitation to end life. Then the patient is asked to construct a thermometer on a large piece of construction paper. On one side of the thermometer, she should list from top to bottom all of her most familiar unsafe feelings. On the other side of the thermometer, she must describe the ways she currently copes with each of these feelings or sets of feelings. The coping section should initially be written in pencil

because that will become the focus of work in therapy on how to elaborate healthier, more thoughtful, more present day-oriented ways of dealing with these unsafe feelings. Often it is even more productive for both patient and therapist to do all or part of the Safety Thermometer in session. This approach helps the patient to get started and the therapist to spell out clearly how to think about the connection between what the patient feels and what she does. Just the task of making those types of connection helps to combat impulsivity because the patient can see the degree to which the helplessness of her childhood has carried over to her adult life. In the face of profound feelings of self-loathing and overwhelming urges to hurt her body, she is essentially passive, waiting for someone to come and rescue her, or in collusion with her abusers, intensifying the very feelings that might jeopardize her life by perseverating on them until they begin to feel more and more true. When patient and therapist begin to work on exactly what the patient can actually do in the face of each category and intensity level of affect, it can be a very empowering experience. [A tip: if the patient absolutely cannot think of anything healthy she could do to cope with a particular set of affects and/or insists that she can't possibly do any of the things that you suggest, ask her how she survived as a child: how she spent her time when she was not being abused, how she was able to keep going day after day. Explain to her that even a child caught in an impossible situation from which there is no way out instinctively finds ways to cope, and she must have or she would not have survived. Explain that, even though she as an adult has many more options than she did as a child, her feeling memories of helplessness and hopelessness may interfere with her use of those options.]

Learning to contract.

Most therapists are familiar with basic safety contracts because it is part of our training in risk management. In working with trauma survivors, however, contracting is often difficult because these patients are exquisitely sensitive to issues of power and control. Agreeing to contract may often bring up resistance and rebellion ("you can't make me"), or it may increase the sense of powerlessness ("if it weren't for my therapist, I might be dead"). The best approach to contracting emphasizes defining the commitments the patient has to make in order to recover, whether it is to refrain from self-harm, come to appointments consistently, lead a more structured daily life, or go to AA meetings even if she hates them. Ideally, we want the patient to contract with herself if at all possible. If feelings of worthlessness interfere with her ability to contract for herself, then the contract can be a contract with herself to commit to her recovery or to the therapy. If contracting is difficult because the patient does not have confidence in her ability to keep herself safe, then she can also be taught to break down the steps into smaller pieces: for example, rather than "I will keep myself safe," it may have to be, "I will use my Survival Kit each time I feel _____." If she is resistant to the whole idea of contracting, a piece of psychoeducation is in order: for example, she may need to learn that healthy families commit to keep their children safe even if it means self-sacrifice and that she lost the opportunity to learn about these kinds of commitments by virtue of growing up in an unsafe environment. The most frequent mistake we as therapists make in work on contracting is not to follow up when a patient breaks a contract either with us or with

herself. We need to be teachers: Why didn't the contract hold? How do we need to change it so that it will work the next time she feels unsafe? Does it need to include more strategies for how to keep herself safe?

Learning to anticipate.

Because impulsivity and intrusive symptoms are much harder to control once they become intense, a patient's best opportunity for stabilizing herself is before, rather than after. Each time a patient self-harms or acts out, my first question is, "What was the trigger?" or "Did you notice any early warning signs?" "Looking back, what were the early warning signs you might not have seen at the time?" Going over the days or hours preceding each episode of self-harm is very tedious but very rewarding.
Look for triggers (that is, reminders, subtle or not so subtle, of past traumatic experiences). Look at what response the patient had to the triggers and how that led to the next step and the next and the next. Keep asking, "What did you do to try to help yourself?" If the answer is, "Nothing-what could I do?", you know that you have a piece of psychoeducation to do to help the patient see the array of options she has at any given time coupled with why she has so much difficulty seeing them in the moment. In these detailed analyses, the therapist has wonderful opportunity to help the patient anticipate the next crisis and to continue to build up her store of psychoeducational information. In addition, unsafe behavior loses its negotiating "currency" if it remains a central focus of treatment but is not just a way to call for rescue or to communicate feelings or to prove the survivor's power over life and death. The work around safety is monotonous and repetitive, and most of it is ideally done before the patient actually acts out the unsafe impulses. Richard Kluft speaks of "boring his patients into health." Ideally, we should bore our patients into stability.

Work on anticipation is not only useful in the wake of an episode of acting out; it is also useful prospectively. For example, if the patient is currently having a lot of unsafe feelings or is about to embark on a stressful experience (going to a job interview, going out on a date, going home to visit family, using public transportation, having to get through the therapist's vacation), spending therapy time going through a rehearsal of how to cope in anticipation is extremely valuable. Encourage the patient to problem-solve each step leading up to the event, beginning at whatever point anxiety will mount or she is likely to get triggered. Use psychoeducation to decrease resistance: children raised in safe, healthy environments learn as they grow how to anticipate what will be hard for them and what they will do about it, largely through modeling. Teach the patient to anticipate the worst but not expect it. (Typically, trauma survivors expect the worst but then anticipate the best or fail to prepare for either-a dangerous strategy.)

Calming the mind and body.

These are skills crucial for stabilization and ultimately processing and integration of the trauma. It helps to begin with an explanation about how PTSD causes hyperarousal, how

traumatic experiences interfere with the inborn ability to regulate emotional intensity and result in a chronic pattern of alternating hyper- and hypo-arousal. The metaphor of an Emotional Thermostat in the brain helps most patients to understand the concept. I explain that the ability of the Emotional Thermostat to automatically keep intense feelings from getting too intense (too hot) or getting disconnected (too cold) is lost when children are exposed to chronic trauma, and the result is that the emotional temperature of the survivor is either too hot or too cold and does not re-regulate automatically. This means that the patient will have to acquire the ability to "manually" regulate the emotional thermostat. Initially, this skill can be taught by having the patient practice using the intellect to calm and reassure the feelings. In part, she has already learned something about this skill if the metaphor of the Emotional Thermostat has fostered greater intellectual understanding which she can use to reassure herself that she is not crazy or over-reactive. Most therapists have the skill of using cognition to regulate emotion, but our patients must be explicitly taught how to talk themselves through a crisis, how to calm their right hemispheres using the language and executive functions of the left hemisphere. They also need to be taught to calm the body, and that is best done by teaching them breathing techniques. In addition to the standard instructions for meditative breathing (differentiating diaphragmatic and chest breathing, focusing on the breath, allowing their breathing to gradually become slower and calmer, noticing the effect on the body), it is helpful for trauma survivors to have a mantra or affirmation to focus on while breathing in order to help focus attention away from the intense affect or possible intrusions. For example, they can be taught to breathe in the quality or state of mind they need (such as "I breathe in safety" or "I breathe in calm") and to breathe out the affect that is overwhelming ("I breathe out pain" or "I breathe out fear"). [A caveat: for some trauma patients, breathing techniques are contraindicated at first because they raise hypervigilence and escalate anxiety. For these survivors, relaxation is equated with being vulnerable to danger, and they need instructions which emphasize that relaxation is not incompatible with alertness, such as "I breathe in alertness" or "I can calm my body and alert my mind."]

Learning how to stay in the present.

This is the skill that is probably the most useful for any trauma survivor over the length and breadth of her recovery. That is because PTSD and Dissociative Disorders are fundamentally thought disorders in which past becomes present and present becomes past. In a flashback or nightmare, for example, intrusive and sensory memory experiences overwhelm the reality-testing capacity of the human mind. When the sensory modality of this intrusive re-experiencing is tactile or affective or kinesthetic or olfactory, most patients believe that the flashback is a piece of present reality and try to interpret the experience in that light. From the first interview with a patient, we should be teaching about intrusive symptoms and their meaning. When a patient complains of feeling terrified in a context that would not evoke terror or of feeling overwhelming shame in the face of an experience which would be mildly embarrassing for most people, they need to know that they are having "feeling flashbacks," not living in a world that is dangerous and humiliating. Many patients do

not realize that "flashbacks" are not just visual and rarely, if ever, narrative. Most flashbacks are fragmented sensory experiences involving affect, vision, tactile, taste, smell, auditory, and motor systems. Most intrusive symptoms are affective, not visual. "Learning to stay in the present" starts with leaning how to correctly interpret the messages of mind and body in response to current reality when one is a survivor of trauma.

For example, a key concept is the notion that intense and overwhelming feelings only occur in the present in response to an immediate, obvious danger. Terror is appropriate if and only if you are facing an avalanche or speeding vehicle or a mugger or a mountain lion. Rage in the present only occurs in the context of aggression, such as seeing someone being physically assaulted, especially if it is a loved one. Grief is appropriate if someone has died or a relationship has ended. If any of these intense, overwhelming feelings occur in the everyday present, then they must be "feelings from the past." This might seem a very simplistic model, but it is liberating for trauma survivors once they grasp the premise.

Early on, I teach this skill by having the patient learn to identify "feeling flashbacks" (or affective intrusions) and "long, slow flashbacks" (the hours and days spend on a self-destructive course or in a dissociated state apparently outside of their control). For example, if a patient reports having been afraid to leave her apartment all week because of panic symptoms, she needs to be given psychoeducational input: her panic symptoms are affective memories of chronic fear she experienced as a child about what would happen next. It occurs more often at home because her home was the context in which she was in danger then. She responded to those panic symptoms as if they were indications of some danger in her current reality, and she placed the danger outside the home instead of inside, as she may also have done as a child. An example of a "long, slow flashback" comes from a consultation case: after six years of therapy, the patient had been able to graduate from a professional school as she had always dreamed of doing but, just before her graduation, an abusive ex-partner took out a restraining order against the patient as a retaliatory gesture. The coincidence of these two events triggered a massive decompensation in which the patient went from being able to function as student and mother despite her PTSD symptoms to spending all day everyday lost in thoughts of despair and self-loathing. She retained the ability to care for her child as a kind of "splinter skill" but lost almost all of her previous functioning ability. She was post-traumatically "stuck" in a past time when every childhood accomplishment could and often would be destroyed by one of the several perpetrators in her family with the admonition that she had brought this abuse upon herself because she was so bad and so evil. The combination of a major success in her life and being unjustly blamed for the actions of another triggered a months-long episode in which she re-lived the helplessness, the powerlessness, and the sense of badness of those years. Following the consultation, the therapist began to help the patient begin a job search in her chosen profession in an effort to help her "return to the present". Within a month, the patient had a job and was fully recompensated. As in this example, just the action of identifying the symptom as a symptom of PTSD instead of a statement about reality has a calming and centering effect.

Another useful technique for delineating past as separate from present is the Emotional Yardstick which can be employed when patients report having had feelings which either they or the therapist realize were out of keeping with the present context. The patient is asked to represent how intense the feeling was by spreading out her arms in a "this big" gesture. Then I ask, "What percent of your [feeling] fits with what just happened in the here-and-now? How much of it is probably about [the aspect of the trauma and neglect which would have caused the same feeling]?" Most patients are remarkably quick to grasp the idea without a great deal of psychoeducation and will immediately acknowledge that 80% or 90% of the affect is driven by the past. If the patient adamantly believes that the feelings are primarily driven by her current circumstances and has little to do with past trauma, that is a sign to the therapist that a focus on psychoeducation is urgently needed. Any if not all of the patient's perceptions need to be gently but persistently challenged with input to help her differentiate between what I label "objective reality" and "post-traumatic reality". For example, if she describes her intrusive, annoying female neighbor as "unsafe," I will stop and re-frame the statement by saying perhaps, "Not unsafe-triggering, intrusive, annoying but not unsafe. Unsafe people threaten your existence or your human rights or your body." Or I will use the statement as an opportunity to teach the patient more about triggering: "Do you know why her behavior was so triggering for you? What about it might have reminded you of the unsafe people in your life?" As she increases her ability to make these differentiations, the use of the Emotional Yardstick will have greater positive effect. Over time, the patient can be taught to use it to keep feelings in better perspective in the moment by learning to "measure" a reaction before responding to the person or situation.

Another way in which the differentiation of past and present can be taught is through psychoeducation, through teaching the patient to recognize post-traumatic reactions and symptoms as they occur in the course of her daily life. One of the tragedies of childhood abuse is that the minute details of ordinary life and ordinary relationships comprise the biggest source of triggers of PTSD symptoms because it was in the context of such ordinary events that the child was repeatedly traumatized. (I often make the analogy to patients that going through a typical day for them is like a return trip to Vietnam for a veteran.) Asking the patient to notice how the non-traumatized people in her life respond to events or having her imagine how a non-traumatized person would respond can elicit her own awareness that trauma changes how we react to environmental stimuli. As the therapy progresses, we will eventually work on grounding techniques for "coming back into the present" when something in the present triggers the past. And further along yet, patients will learn to anticipate or recognize immediately when past and present are becoming confused and to use their skills to stay in the present. [A caveat: it is extremely difficult to work on this skill if patients have no meaningful life in the here-and-now. They need to have some activities in their lives which ground them in the present to fully benefit from any kind of recovery program or therapy, whether those activities are hobbies, volunteer, creative activities, family or work.]

The essence of stabilization work is getting cognitive distance from overwhelming affect. If we recall the evidence of Bessel van der Kolk's brain-imaging studies, post-

traumatic affective intrusions are accompanied by relative inactivity in the left hemisphere, particularly the language areas, and heightened activity in the amygdala and other areas related to sensory memory. We might want to understand stabilization then as a piece of work in which the patient learns to use the left brain's capacity for analysis and planning to help the right brain with overwhelming feelings and sensations and perceptions. Stabilization is a prerequisite for working through the trauma because otherwise "working through" will be re-traumatizing: intrusive affects will overwhelm the patient without her permission and leave her feeling depleted and demoralized, just as she felt at the time of the original trauma. I like to think of stabilization work as giving the patient a sense of mastery over the process of remembering: when she decides that she is ready to remember and re-live the trauma on her terms, she will be empowered rather than disempowered and re-traumatized. For those of us who have difficulty seeing stabilization work as "therapeutic", it is important not to underestimate the impact of helping our patients to attain the sense of mastery over their present that they never had over the past. As Judy Herman tells survivors, "It is bad enough that you were robbed of your childhood—it is unacceptable to also lose your opportunity to live in the present."