Experiential Therapies for Treating Trauma

Edited by
Evan Senreich,
Shulamith Lala Ashenberg Straussner
and Jordan Dann

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Experiential Therapies for Treating Trauma offers 17 chapters, with 15 of them focusing on a different experiential psychotherapy for treating trauma, written by clinicians with expertise in that modality. No other book contains descriptions of such a wide array of experiential therapies under one cover. Readers will obtain both a comprehensive overview of the many experiential therapies that are currently utilized and specific knowledge regarding how to utilize each of them in psychotherapy practice. The authors of each chapter emphasize that in working with clients impacted by trauma, there is a need for the use of therapeutic modalities that go beyond the cognitive processes central to talk therapy and incorporate more holistic, sensory approaches that emphasize the building of a strong relationship between the client and therapist. Both experienced clinicians and students will find this book to be an invaluable resource to enhance their knowledge of how to use experiential therapies and to motivate them to obtain advanced training in modalities that spark their interest.

Evan Senreich, PhD, LCSW, is a professor of social work at Lehman College, City University of New York, and a graduate of Gestalt Associates for Psychotherapy in New York.

Shulamith Lala Ashenberg Straussner, PhD, LCSW, is professor emerita of New York University and was honored by NASW as a Social Work Pioneer for contributions in the areas of trauma and addictions.

Jordan Dann, LP, is the author of *Somatic Therapy for Healing Trauma* and a faculty member at Gestalt Associates for Psychotherapy in New York.

A must read! There is a slow but sure consensus growing among mental health professionals and researchers that experiential work is a missing key ingredient to achieving profound clinical change. Many already suspect this but wonder how to actually implement it with their clients. This important volume answers this question, providing clear rationales, guidelines, and examples on how to unlock the powerful benefits of experiential treatments.

Alexandre Vaz, *PhD, director of training, Sentio Marriage and Family Therapy Program and Sentio Counseling Center*

Every psychotherapist must learn about trauma and its treatment, and the field of contemporary psychotherapy includes more methods and forms of treatment than ever. This timely and tremendously valuable book provides a clear, balanced, and conveniently structured resource for understanding the similarities, differences, strengths, and limitations of therapies from an essential domain of trauma treatment.

David S. Elliott, *PhD, co-author of Attachment Disturbances in Adults*

Experiential Therapies for Treating Trauma is a well-written book about an area of importance to all counselors and psychotherapists. The format offers the reader an opportunity to sample 15 different evidence-based approaches described by experts. I appreciated its breath and depth. It is a must read for anyone who works with trauma, whether a beginner or expert. I highly recommend it.

Joseph Melnick, *PhD, founding editor of Gestalt Review and co-author of The Evolution of the Cape Cod Model: Gestalt Conversation, Theory and Practice*

Highlighting the critical role of the body in trauma recovery, Experiential Therapies for Treating Trauma is a vital resource for practitioners looking to deepen their understanding of integrative approaches to healing.

Scott Lyons, *founder of the Embody Lab*

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EVAN SENREICH, SHULAMITH LALA ASHENBERG STRAUSSNER AND JORDAN DANN

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ABOUT THE CONTRIBUTORS

Lia Avellino, LCSW
Psychotherapist, columnist, and CEO of Spoke Circles, LLC
MSW from Columbia University School of Social Work, 2016

Sara K. Bridges, Ph.D.
Associate Professor of Counseling Psychology, The University of Memphis
Ph.D. from the University of Memphis, 1999
Co-director, Coherence Psychology Institute

Haydn Briggs LCSW, CGP, CET III
Founder and director, Healing Self Psychotherapy
MSS from Bryn Mawr College, 2020

Jennifer Byxbee ART-BC, LCAT, CGT
Founder of Creative Arts Psychotherapy NYC
Masters in Professional Studies from the School of Visual Arts, Art Therapy, 2007

Alan Cohen, LCSW, LP
Senior faculty, Gestalt Associates for Psychotherapy
MSW Washington University, St Louis, 1974
Visiting faculty, GATLA International Training Conferences

Jordan Dann, LP
Author of *Somatic Therapy for Healing Trauma*
Creator of the "Relationship Transformation School"
Faculty, Gestalt Associates for Psychotherapy

Bruce Ecker, MA, LMFT
Co-director, Coherence Psychology Institute, LLC
M.A. from John F. Kennedy University, 1984
Independent psychotherapy practice

Anna Gartshore, MSW, RSW
Registered social work psychotherapist in private practice, Ontario, Canada
MSW from Laurier University, Lyle S. Hallman Faculty of Social Work, 2009
IFS Institute Approved Clinical Consultant and Trainer

Scott Giacomucci, DSW, LCSW, BCD, CGP, FAAETS, TEP
Director, founder, and owner, Phoenix Center for Experiential Trauma Therapy, Media, Pennsylvania
Adjunct professor and research associate, Bryn Mawr College Graduate School of Social Work and Social Research
Author of *Social Work, Sociometry, & Psychodrama* (2021) and *Trauma-Informed Principles in Group Therapy, Psychodrama, & Organizations* (2023)

Amanda Garcia Torres, LMHC
Co-Director, Chairwork Psychotherapy Initiative
Master of Arts in Counseling for Mental Health and Wellness, New York University, 2014
Certified chairwork psychotherapist

Amy Gladstone, PhD, LCSW
Professor of Social Work, Seton Hall University
Faculty, Sensorimotor Psychotherapy Institute
Faculty, Integrative Trauma Program, National Institute for the Psychotherapies

Benjamin Kagedan, PsyD, CHT, PATP
Practitioner and supervisor in somatic and psychedelic therapies
Psy.D. from Rutgers University Graduate School of Applied and Professional Psychology, 2017
Faculty, Hakomi Institute

Scott Kellogg, PhD
Director, Chairwork Psychotherapy Initiative
Ph.D. in Clinical Psychology, Graduate Center of the City University of New York, 1994
ISST–Certified Advanced Schema Therapist

Ben Medley, LCSW
Senior faculty, AEDP Institute
M.S.W. from NYU Silver School of Social Work, 2006

Patricia O'Keefe Monteleone, LCSW
Psychotherapist; trauma specialist
ISTDP Core Training
Parnell Institute Faculty, Consultant and Facilitator
EMDRIA Consultant

Jeffrey L. Morrison, MA, LMHC
Certifying coordinator and focusing trainer
Executive director of the Seattle Focusing Institute
MA in Existential Phenomenological Psychology, Seattle University, 1986

Noora Niskanen, LCSW, MFA
EMDR trauma therapist in private practice, New York, NY
MSW from Lehman College, City University of New York, 2012
MFA from NYU, 2006

Riley Paterson, MA, LMHC
Psychotherapist in Seattle, Washington
Master of Arts in Psychology from Seattle University, 2019

Benjamin Seaman, BFA, LCSW
Certificate in Psychoanalytic Psychotherapy, Psychoanalytic Psychotherapy Study Center
Psychotherapist in private practice
Former adjunct lecturer, NYU Silver Graduate School of Social Work

Evan Senreich, PhD, LCSW
Professor of social work, Lehman College, City University of New York
Ph.D. New York University Silver School of Social Work, 2007
Graduate of Gestalt Associates for Psychotherapy, 1994
Author of over 40 published research and conceptual journal articles

Rebecca Stone, LCSW
Founder and clinical director, Brooklyn Somatic Therapy
Certified teacher, The Hakomi Institute
Certified EFT therapist and supervisor candidate
MSW from Silberman School of Social Work, Hunter College, 2014

Shulamith Lala Ashenberg Straussner, PhD, LCSW
Professor Emerita, New York University Silver School of Social Work;
Founding editor, *Journal of Social Work Practice in the Addictions*
NASW Social Work Pioneer;
Fulbright Scholar; board member, *Fulbright Israel Interest Group*

Dennis Tirch, PhD
Founding director, The Center for Compassion Focused Therapy
Chairperson, The Compassionate Mind Foundation, USA
Past president and Fellow, Association for Contextual Behavioral Science

Talya Vogel, PsyD
Director of Trauma, Transformation, and Resilience (TTR) Program, The Center for Compassion Focused Therapy
Senior psychologist, The Center for Compassion Focused Therapy
Psy.D. from PGSP-Stanford PsyD Consortium, 2020

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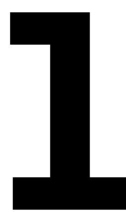

CHAPTER 1
INTRODUCTION

Overview of Experiential Psychotherapies for the Treatment of Trauma

Shulamith Lala Ashenberg Straussner,
Evan Senreich and Jordan Dann

Addressing traumatic experiences is a frequent occurrence in current psychotherapy practice. Many contemporary authors and clinicians who focus on the treatment of trauma point out the need for the use of therapeutic modalities that go beyond the cognitive processes central to talk therapy and incorporate more integrative, experiential sensory or somatic approaches (Dann, 2022). The number of experiential psychotherapies has grown substantially over the past four decades, and there is a great need for practicing clinicians and students to become familiar with the variety of these newer treatment approaches. This book provides an overview of 15 different types of contemporary experiential psychotherapies and how each one can be utilized in the treatment of trauma. The chapters include a brief history of a specific experiential psychotherapy approach, its main clinical concepts, how it is practiced, an assessment of its evidence base and how it can be utilized in the treatment of trauma utilizing fictional case examples.

This introductory chapter has four sections. In the first, the definition and characteristics of experiential psychotherapy are briefly delineated. The second section presents an overview of trauma and clinical issues pertaining to it. This is followed by a section on the neurophysiology of trauma and how this knowledge can be applied when using experiential therapies. The final section provides a historical overview of experiential psychotherapy and includes a brief description of the 15 treatment modalities presented in this book.

EXPERIENTIAL PSYCHOTHERAPY: DEFINITION AND DESCRIPTION

The term *experiential therapy* applies to an increasing number of psychotherapeutic modalities developed since the mid-20th century (with the exception of psychodrama) that share a number of common features. In defining the key element of experiential therapy, the American Psychological Association's (APA) *Dictionary of Psychology* states:

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> A core belief of the approach is that true client change occurs through direct, active experiencing of what the client is undergoing and feeling at any given point in therapy, both on the surface and at a deeper level.
>
> (VandenBos & American Psychological Association, 2015, p. 396)

In other words, in experiential psychotherapies there is less emphasis on clients talking about current and former life events in a narrative form and much greater focus on what the client is fully experiencing in the room in the presence of the therapist. In addition, many of the early experiential therapies were developed in tandem with humanistic approaches, such as the person-centered psychotherapy of Carl Rogers and the existential psychotherapy of Rollo May, Irvin Yalom, and others. Therefore, there is usually a strong emphasis in experiential therapies on the importance of an authentic relationship between the therapist and client, in which the latter feels that their worldview is confirmed and validated (Watson et al., 1998). Geoghegan (2019), a contemporary practitioner of coherence therapy, has clearly delineated five key characteristics that specifically apply to the vast majority of experiential psychotherapies described in this book. First, the therapist utilizes prompts during sessions to tap directly into the client's experiences in the moment rather than just talking about the client's life experiences. Second, the therapist encourages the client to attend closely to sensations and feelings that occur during the session in a mindful way. Third, experiential therapists do not take on the role of expert, but instead foster a collaborative relationship with clients, assisting them to discover and integrate the disparate parts of their selves. Fourth, in order to alleviate the client's symptoms, the therapist does not try to counter or override them, but instead focuses on their meaning. Last, Geoghegan emphasizes that by demonstrating a genuine curiosity about the client's perceptions without challenging them, a warm relational field is developed in which clients feel respected, valued, and safe.

It is important to clarify that the attention paid to clients' experiences during the therapy session does not in any way de-emphasize the importance of processing life events outside of the therapy room. However, whereas most psychotherapy modalities focus on the client's discussion of these events, experiential therapies stress that the client explore their *current* thoughts, feelings, and body sensations regarding these events while in the presence of the therapist. This is particularly important when assisting clients working through past traumas while at the same time focusing on their lived experiences in the room within the context of a warm, reparative client-therapist relationship.

Although most experiential therapies include the five key elements identified here by Geoghegan (2019), there is considerable diversity among them regarding theorical orientation, terminology, and practice. However, the development of a number of these experiential therapies were profoundly influenced by each other. Therefore, it is quite common for contemporary experiential clinicians to be trained in more than one such approach and to utilize elements of more than one experiential modality in their psychotherapy practice.

OVERVIEW OF TRAUMA AND TRAUMATIC EXPERIENCES

The term "trauma" comes from the Greek language meaning a "wound" or "hurt" (Oxford Dictionaries, 2013). Psychologically, "trauma" refers to an experience that is emotionally painful, distressful, or shocking; one that often has long-term negative mental, physical, and neurological consequences. An event is thought to produce a traumatic response when the stress resulting from that event overwhelms the individual's psychological ability to cope.

Although we often think of trauma as being synonymous with the identified *objective* cause of the trauma, such as a woman being raped or someone who has experienced war-related violence, the effect of the trauma is always *subjective* and refers to the impact – the perceived "wound" or "hurt" as identified by the early Greeks – that it has on the individual (Straussner & Calnan, 2014). Thus, what might be a traumatizing, life-shattering event for one individual might have minimal effects on another. Such differential reaction is based on many factors, including the individual's age, sex and gender, pre-morbid ego strength, genetics, epigenetics, previous traumatic experiences, the chronicity of the trauma, family history of trauma, current life stressors, social supports, and one's cultural, religious, or spiritual attitude toward adversity (Amir & Lev-Wiesel, 2003; Straussner & Phillips, 2004).

HISTORICAL AWARENESS OF TRAUMA

Awareness of the destructive physical and mental impact of trauma was first identified centuries ago by the ancient Egyptians and Greeks in relation to historic wars, as reflected by the writings of the Greek historian Herodotus in the 5th Century BCE. In the 17th Century, Swiss and German military physicians identified illnesses that caused combat soldiers to experience such symptoms as melancholy, physical weakness, anxiety, insomnia, heart palpitations, and homesickness (Osei-Boamah et al., 2013). In the United States, the growing recognition of trauma-related symptoms can be traced to the US Civil War, where they were known as "irritable" or "soldiers' heart" conditions (Pizarro et al., 2006). The terms "combat fatigue" and "shell shock" were introduced during World War I, while Freud suggested that these mental symptoms represented "combat neurosis" that resulted from the conflict between a soldier's "war ego" and "peace ego" (Jones, 1918). During and following World War II the cluster of trauma symptoms that manifested in soldiers were referred to collectively as "war neurosis" (van der Kolk et al., 2005), and studies of survivors of the Nazi-caused Holocaust (Krystal & Niederland, 1968) and of the atomic bombing of Hiroshima and Nagasaki, Japan by the United States introduced the concept of "survivors' guilt" (Lifton, 1968).

The mental sequelae of traumatic events were early recognized in civilian life as well.

Traumatic reactions to events such as sexual assault or exposure to domestic violence or to deadly accidents has made what was eventually termed post-traumatic stress disorder (PTSD), a widely recognized condition throughout the world. A famous description of

an early civilian accident-related trauma and its impact was that experienced by the writer Charles Dickens who, in 1865, was a passenger on a boat-train to London that derailed, killing and injuring many passengers. Dickens was not hurt and tried to aid the victims, some of whom died while he was trying to help them. The experience affected him greatly, as he lost his voice for two weeks and afterwards tried to avoid travelling by train. Dickens died at age 58, five years to the day after the accident. According to his son, he had never fully recovered from this incident (Lewis, 2012).

NATURE OF TRAUMA: ACUTE, COMPLEX, AND DEVELOPMENTAL TRAUMA

There are many different kinds of traumas and many ways of conceptualizing them. In the contemporary literature, they are often categorized as "acute," "complex," and "developmental" trauma. Acute trauma refers to one-time events that can impact individuals, families, groups, and communities and include physical and sexual assaults; natural disasters such as hurricanes, floods, and wildfires; car or airplane accidents; mass violence; and other traumatizing events. Complex trauma (Herman, 1992) includes ongoing traumatic situations such as physical and/or sexual abuse spanning several years, child abuse, wars, and repeated acts of terrorism. They may also involve being bullied in school or in the workplace (Idsoe et al., 2012), being stalked by someone (Purcell et al., 2005), living in severe poverty (Kiser, 2007), or being the recipient of ongoing individual discrimination because of one's race, religion, gender, or sexual orientation. These traumas often go unrecognized and unacknowledged while still causing much psychic pain and damage to one's mental health and may lead to the development of complex post-traumatic stress disorder (C-PTSD) (van der Kolk, et al., 2005).

The concept of developmental trauma overlaps with complex trauma but relates specifically to issues of attachment. Attachment refers to a psychobiological principle rooted in evolutionary development and agreed upon to be the most significant factor in human development (Bowlby, 1969). It is an inborn primary motivational system that guides interactions between the caregiver and infant and is the governing factor in mediating affective attunement as well as emotional and physiological regulation. The attachment pattern established in early development forms an enduring intersubjective context for the ongoing cognitive, affective, and interpersonal development of the child. Attachment formation also plays a key role in psychosocial functions such as empathy, mentalization, and metacognition, which are key to forming secure and stable social relationships. Early adversity and traumatic experience, such as caregivers' physical and emotional neglect, various forms of abuse, or any environmental factors that lead to a feeling of disorganization or insecurity can result in ongoing developmental trauma throughout early development and into adulthood (Lahousen et al., 2019). According to psychiatrist and trauma expert Judith Herman:

> … repeated trauma in childhood forms and deforms the personality. The child trapped in an abusive environment is faced with formidable tasks of adaptation. She must find a way to preserve a sense of trust in people who are untrustworthy, safety in a situation that is unsafe, control in a situation that is terrifyingly unpredictable, power in a

> situation of helplessness. Unable to care for or protect herself, she must compensate for the failures of adult care and protection with the only means at her disposal, an immature system of psychological defenses.
>
> (Herman, 1992, p. 96)

The recognition and growing literature focusing on adverse childhood experiences, known as ACEs, encompasses a variety of different types of childhood trauma, including but not limited to sexual abuse, family violence, neglect, and poverty (Felitti, et al., 1998). The number of ACEs have been showed to be highly correlated with a person experiencing mental health disorders, substance misuse issues, and even physical health problems later in life.

DIAGNOSING TRAUMA AND POST-TRAUMATIC STRESS DISORDER

The idea that trauma could result in specific clusters of symptoms first became formalized by the inclusion of the diagnosis of post-traumatic stress disorder (PTSD) in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM III; American Psychiatric Association [APA], 1980) under the category of *Anxiety Disorders*. This new diagnosis was precipitated by awareness of the psychological problems experienced by returning Vietnam War veterans in the 1970s and the growing literature by European writers such as Gunter Grass, Primo Levy, and Eli Wiesel among others who survived their own traumatic experiences during World War II and who vividly described the profound impact of mass violence on individuals, families, and communities (Straussner & Phillips, 2004).

In the *DSM-5* (APA, 2013), PTSD was removed from the category of *Anxiety Disorders* and placed under the new category of *Trauma- and Stressor-Related Disorders* along with adjustment disorder, reactive attachment disorder, disinhibited social engagement disorder, and acute stress disorder. Prolonged grief disorder was added to this category in the *DSM-5-TR* (2022). The diagnoses in the *Trauma- and Stressor-Related Disorders* category are distinct among psychiatric disorders in the DSM in that they require exposure to a stressful event as a precondition. Over the years, there has been an increase in the symptom groups required for an individual to receive a PTSD diagnosis. They now include intrusion symptoms, avoidance of stimuli associated with the traumatic event, negative alterations in cognition and mood, and marked alterations in arousal and reactivity.

Although widely debated, what was not included in the DSM-5 was the diagnosis of complex post-traumatic stress disorder (C-PTSD), even though it has been included in the 2019 World Health Organization (WHO) 11th revision of the International Classification of Diseases (ICD-11) (World Health Assembly, 72, 2019). The main differences between diagnosing PTSD and C-PTSD are the length of trauma and the symptoms. Both PTSD and C-PTSD involve symptoms of psychological and behavioral stress responses such as flashbacks, hypervigilance, and efforts to avoid distressing reminders of the traumatic event(s). However, people with C-PTSD typically have additional symptoms, including chronic and extensive issues with emotion regulation, issues with identity and sense of self, and problematic interpersonal relationships often related to such traumatic situations as prolonged domestic violence, childhood sexual or physical abuse, torture, genocide, or

slavery (U.S. Department of Veterans Affairs, 2022). Clinicians with expertise in trauma have noted that most individuals diagnosed with borderline personality disorder (BPD) have been exposed to developmental and/or complex trauma in their early lives, resulting in the emotional pain and interpersonal volatility characteristic of this disorder (Herman, 1992). van der Kolk (2014) reported on a study that indicated that 81% of patients diagnosed with BPD at Cambridge Hospital in Massachusetts were subject to histories of severe child abuse and/or neglect. Earlier, Herman (1992) noted how mental health professionals stigmatize individuals with the diagnostic label of BPD by viewing them as difficult patients, in effect re-traumatizing those who are in desperate need of help due to their early adverse experiences.

More recently, it has been suggested that trauma disorders may be best viewed as a spectrum condition across different DSM diagnoses that share common neurobiological brain features such as smaller hippocampal volume (Bremner & Wittbrodt, 2020). According to this theory, trauma spectrum disorders include PTSD, BPD, dissociative disorders, and a certain subgroup of major depressive disorder. Awareness of the interplay between environmental stressors, especially in early childhood, and their effects on brain and neurobiology across the life span is important in understanding these disorders and in the development of therapeutic interventions (Bremner & Wittbrodt, 2020).

EPIGENETICS AND TRAUMA

While still in its infancy, there is a growing body of research in the study of epigenetics that continues to examine the intersection of nature and nurture, or gene and environment. Epigenetics is defined as the study of changes in organisms caused by modification of gene expression rather than alteration of the genetic code itself. Epigenetics has more recently come to refer to direct alteration of DNA regulation that are "on top of" or "in addition to" the traditional genetic code (Howie et al., 2019). The converging evidence of the field of epigenetics and trauma indicates that exposure to extremely adverse environmental circumstances and events impacts individuals so severely that future generations continue to grapple with the inheritance of that trauma (Yehuda & Lehrner, 2018).

The dynamics of *intergenerational transmission of trauma* were first identified in studies of children of Holocaust survivors (Danieli, 1998; Yehuda et al., 2001). Earlier, in a vivid description of three patients presented for psychiatric treatment, Rakoff (1966) noted,

> The parents are not broken conspicuously, yet their children, all of whom were born after the Holocaust, display severe psychiatric symptomatology. It would almost be easier to believe that they, rather than their parents, had suffered the corrupting, searing hell. (p. 20)

The growing attention in the United States on what is being termed *historical trauma* related to Native American populations (Brave Heart, 1999), and *Post Traumatic Slave Syndrome* (DeGruy, 2017), which focuses on the long-term consequences of slavery on African Americans, points to the increasing recognition and need to address the psychological, social, political, and cultural impact of widespread trauma *over time*. The emerging body

of research on epigenetics and trauma is still very young, but what is evident is that some populations and individuals are more biologically susceptible to PTSD, highlighting the importance of clinicians' socio-cultural competency and the incorporation of understanding how catastrophic historical events and familial history may play a highly significant role in the treatment of trauma and PTSD (Ford et al., 2015).

EPIDEMIOLOGY OF TRAUMA AND POST-TRAUMATIC STRESS DISORDER

The experience of trauma is fairly common. A 2016 general population survey conducted in 24 countries showed that more than 70 percent of respondents experienced a traumatic event, and over 30 percent had experienced four or more events (Benjet et al., 2015). Although there is a lack of recent national epidemiological findings in the United States focusing on trauma, studies during the 1990s found that over 60 percent of men and 51 percent of women reported having experienced at least one traumatic event during their lifetime (Kessler et al., 1995).

Nonetheless, while the experience of trauma is common, PTSD diagnosis is much less prevalent. The estimated lifetime prevalence rate of PTSD in the United States has been found to range between 6.1 to 8.3% percent (APA, 2022), although the initial prevalence rates among active-duty military exposed to war conditions and survivors of mass trauma, such as the 2001 destruction of the World Trade Centers in New York, can be as high as 30 percent (Galea, et al., 2005). According to the DSM-5-TR, the "[h]ighest rates (ranging from one-third to more than one-half of those exposed) are found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide" (APA, 2022, p. 308). While a study published in 2015 found that 6% of a sample of US adults had a lifetime PTSD prevalence, such disorder was twice as high among women (8%) as among men (4%) despite the fact that men are more likely to be exposed to traumatic events (Atwoli et al., 2015). A study based on findings from the 2004–2005 wave of the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC; Roberts et al., 2011) found that the lifetime prevalence of PTSD in the United States was highest among Black individuals (8.7%), intermediate among Hispanics and Whites (7.0% and 7.4%), and lowest among Asians (4.0%). All minority groups were less likely to seek treatment for PTSD than Whites, with fewer than half of minorities with PTSD seeking treatment (range: 32.7–42.0%). Incidence of both trauma and PTSD are higher among lesbian, gay, bisexual, and transgender individuals than among sexual majority individuals. Studies of self-identified gay, lesbian, and bisexual (LGB) individuals found that 83% reported going through adverse childhood experiences (ACE) such as sexual and emotional abuse and having a greater risk for mental health conditions as adults when compared to their heterosexual peers. More than half, 52%, of LGB adults reported three or more ACEs compared to 26% of their heterosexual counterparts (Tran et al., 2022). Reliable prevalence studies on trauma and/or PTSD among transgender individuals are lacking although they are very likely to be much higher than among other populations.

PTSD can affect all aspects of a person's functioning and well-being. It is frequently comorbid with anxiety disorders, major depressive disorder, and substance use disorders, with all of the co-occurring disorders requiring attention during treatment (Qassem et al.,

2021). Overall, PTSD is associated with poorer physical health and greater health care utilization. Findings on mortality are mixed, but generally show that PTSD is associated with increased rates of death due to accidental causes (Goldstein et al., 2016).

THE NEUROPHYSIOLOGY OF TRAUMA AND ITS RELATIONSHIP TO EXPERIENTIAL APPROACHES

Traumatic stress can change the brain's chemistry and structure. Studies suggest that trauma is associated with permanent changes in key areas of the brain, including the *amygdala* – the part of the brain that processes fear and other emotions; the *hippocampus* – the part that is largely responsible for learning and memory; and the *prefrontal cortex* – the part of the brain that is involved in executive functions, such as planning, decision-making, personality expression, and social behavior. The coordination of these three key areas is essential for stress management, affect regulation, and effective functioning of the autonomic nervous system and is associated with increased cortisol and norepinephrine responses to subsequent stressors (Carrion & Wong, 2012). Some neuroimaging studies show that brain changes are more severe in people with C-PTSD compared to people with PTSD.

It is clear that acute trauma, developmental trauma, and C-PTSD all impact both the emotional and physical state of a person. When an individual experiences a traumatic event, the amygdala (emotional and survival center) goes into overdrive and the autonomic nervous system (ANS) goes into survival mode, sending signals to the muscles to prepare for mobilization (fight or flight). If the threat cannot be fought against or escaped from, the autonomic nervous system utilizes its third threat response: Freeze. The freeze response initiates an emotional and psychological shutdown, a safety mechanism to prevent the psyche from becoming too overwhelmed. Meanwhile, trauma also leads to reduced activity in the hippocampus, one of whose functions is to distinguish between the past and present. In other words, the brain cannot tell the difference between the actual current traumatic event and a memory of it. It perceives things that trigger memories of traumatic events as threats themselves. Consequently, during a future time, the nervous system can misinterpret safe environments or situations as life-threatening, leading to the use of maladaptive responses (Ehlers, 2015).

Terpou et al. (2019) differentiated PTSD symptoms into two categories with opposing physiological defense reactions: 1. Hypervigilance and exaggerated sensitivity to stress with increased sympathetic nervous system activation, usually as a result of a single traumatic event; and 2. Hypoemotionality, emotional detachment, and dissociation with decreased sympathetic nervous system activation and increased parasympathetic nervous system functioning usually as a sequela to chronic physical, sexual, and psychological (complex and developmental) trauma where escape was not possible. In addition to the two hyperarousal responses of fight (confronting the threat) or flight (running away from the threat) and the hypoarousal response of freeze (shutting down to block out the threat), some trauma clinicians have added the "fawn" or "appeasement" response, which refers to ameliorating

the traumatic threat through pleasing the perpetrator through compliant, servile behaviors (Bailey et al., 2023; Ryder, 2022).

THE BENEFITS OF UTILIZING EXPERIENTIAL THERAPIES

The difficulty with effectively treating trauma with traditional talk therapy is that traumatic situations may result in the blocking of critical cognitive brain processes that are essential for integrating the past, often resulting in the patient reexperiencing rather than resolving the trauma (van der Kolk, 2014). Individuals suffering from the effects of trauma usually report uncontrollable emotions and somatic sensations triggered by reminders of the traumatic situation experienced over and over again in their bodies. The ability to integrate the traumatic memories into a cognitive life narrative are often not available to them, but instead continue to live on somatically, creating a "speechless terror" (Ogden, 2006, p. 28).

Due to the nature of the complex imprint of painful and terrifying unprocessed somatic memories resulting from exposure to traumatic situations, experiential psychotherapies can be particularly helpful as treatment options (Dann, 2022). As many psychotherapy clients who have experienced trauma may not particularly benefit from insight and cognitive-oriented therapies, experiential therapies may be beneficial in enhancing their awareness of their somatic sensations and their physical action patterns (van der Kolk, 2006). Most experiential therapies emphasize a "bottom-up," as opposed to a "top-down" approach to treatment. Top-down processing refers to the prefrontal cortex using current and past information to interpret a situation and involves logic, planning, and problem solving (Reagan, 2021). In traditional top-down talk therapy, the goal of treatment is for the prefrontal cortex to integrate new cognitive perspectives about a difficult situation, which will then result in modification of one's emotions and behaviors. Modalities such as psychodynamic psychotherapy, cognitive-behavioral therapy, dialectical behavior therapy, and solution-focused therapy use such an approach. However, since top-down processing is often impaired in trauma survivors, the experiential therapies incorporate a bottom-up approach that uses bodily sensations and movements to access the trauma and process the impact of it. This is not to say that the experiential therapies do not utilize aspects of a top-down approach as well, but they all emphasize the clients' immediate experiences and bodily sensations.

HISTORICAL OVERVIEW OF THE DIFFERENT EXPERIENTIAL PSYCHOTHERAPIES

The following briefly describes notable experiential psychotherapies in the context of their historical roots. All 15 of these modalities are included as separate chapters in this book. Probably the oldest experiential therapy that is still utilized is *Psychodrama*, developed as one of the first forms of group therapy in the first decades of the 1900s in Vienna, Austria by Jacob L. Moreno, in which participants act out important scenes in group members' lives

and process them together (Hough, 2014). However, *Gestalt therapy*, created by Fritz Perls, Paul Goodman, Laura Perls and others in the early 1950s probably had more influence over the early development of experiential therapy than any other modality. Developed as a counterpoint to the reductionist and authoritarian nature of Freudian psychoanalysis, it has been referred to as a "phenomenological" therapy, in which the immediate experiences of clients are focused on in great depth in the here and now of the therapy room (Yontef, 1993). Its theoretical underpinnings were borrowed from many schools of thought such as Gestalt psychology, Lewin's field theory, Reichian body-oriented psychoanalysis, the phenomenological philosophy of Husserl, and the dialogic philosophy of Martin Buber, as well as Zen Buddhism (Bowman & Nevis, 2005). In the Gestalt therapy's use of the "empty chair technique," the influence of psychodrama is apparent.

Strongly influenced by Gestalt therapy, *Hakomi therapy* was developed by Ron Kurtz in the late 1970s and *Emotion Focused therapy* was created by Leslie Greenberg and Sue Johnson in the 1980s. In comparison to Gestalt therapy, Hakomi therapy attends far more to clients' somatic experiences and also emphasizes mindfulness, a concept that was not commonplace at the time of its creation (Bageant, 2012; Kurtz, 2020). Emotion focused therapy presents a highly developed theory regarding emotions with an array of techniques to provide adaptive emotional responses to life experiences (Watson, 2018). Gestalt therapy, with its emphasis on clients' experiential exploration of the different parts of themselves, also influenced the creation of *Internal family systems therapy* by Richard Schwartz in the 1980s (Zur Institute, 2023). This modality, which has become increasingly utilized in the past decade, focuses intensely on the client's system of different internal personalities created to keep deep emotional pain at bay (Anderson et al., 2017). *Transformational chairwork*, an experiential therapy developed by Scott Kellogg in the last two decades, expands greatly on Gestalt therapy's use of the empty-chair technique (Kellogg & Garcia Torres, 2021).

Focusing is a very important modality in the history of experiential psychotherapy that was developed by Eugene Gendlin in the late 1960s outside of the influence of Gestalt therapy.

Gendlin worked with Carl Rogers and performed research regarding which clients were more likely to benefit from psychotherapy. He found that when clients were able to intuitively attend to their internal body experiences during the therapy process, which he referred to as a "felt sense," they were more likely to have successful treatment outcomes (Gendlin, 1981).

Consequently, Gendlin developed ways to instruct clients how to develop this "felt sense." This developed into a modality called *focusing-oriented/experiential psychotherapy*. With its focus on attunement to bodily sensations, mindfulness, affect, and emotional self-regulation, Gendlin's work had a major influence on the development of the more somatic-oriented experiential therapies, specifically *Hakomi therapy* and *somatic experiencing therapy*, and furthermore impacted the creation of the concepts of *emotion-focused therapy* (Cornell, 2013).

In regard to the somatic-oriented therapies, Hakomi therapy's focus on clients' bodily sensations led directly to the creation of *sensorimotor psychotherapy* by Pat Ogden in the 1980s, a modality that focuses on working experientially with the physiological manifestations

of trauma and early life attachment issues (Fisher, 2019). Another increasingly utilized trauma-focused experiential therapy with a different line of development and conceptual framework is *somatic experiencing therapy*, created by Peter Levine beginning in the 1970s (Brom et al., 2017). There has been a surge of attention to these two somatic therapies in recent years with clinicians emphasizing the need for bottom-up therapy approaches to treatment to counteract the neurological damage incurred by trauma (Bergner, 2023).

A number of experiential therapies were developed mostly apart from the aforementioned influences. The theoretical basis of *intensive short-term dynamic psychotherapy (ISTP)*, developed in the 1970s by Habib Davanloo, is rooted in psychoanalytic psychotherapy. Focusing on the phenomenon of client resistance, Davanloo developed unique experiential interventions to facilitate the client's visceral experiences of underlying defended emotions (Wolff, 2013). Influenced by Davanloo's work, as well as positive psychology, emotion focused therapy, and especially attachment theory, Diana Fosha developed *accelerated experiential-dynamic psychotherapy (AEDP)* in the early 2000s (Ely, 2023; Tunnell & Osiason, 2021). Fosha (2021) describes AEDP as a highly collaborative, transformative psychotherapy that focuses experientially on the processing of overwhelming, traumatic life experiences and through a trusting therapeutic relationship "seeks to engender new experiences of feeling understood, of recognizing and expressing emotional truths that previously have gone unacknowledged and of integrating positive affective experiences linked to healthy action tendencies and resources" (p. 5). *Coherence therapy*, created in the 1990s by Bruce Ecker and Laurel Hulley, is an experiential therapy in which the emotional truth of the client's disturbing symptom is strongly validated in the immediacy of the therapist-client relationship and then later juxtaposed with an alternative emotional truth experienced by the client that is not in synch with that symptom (Ecker & Hulley 2015; Rice, Neimeyer & Taylor, 2011). *Compassion focused therapy*, developed by Paul Gilbert in the early 21st century, focuses on the client being able to develop affiliative rather than hostile emotions toward the self. Recognizing that clients are often cognitively aware of the lack of truth in their self-attacking thoughts associated with previous trauma without being able to internalize more positive feelings about themselves, this modality incorporates experiential methods to enhance self-compassion (Gilbert & Irons, 2015; Irons & Lad, 2017). Perhaps the most widely used experiential psychotherapy for treating trauma is *eye movement desensitization and reprocessing (EMDR)*, which was created in the late 1980s by Francine Shapiro outside of the influence of many of the other modalities. As originally formulated, this modality involves a methodical treatment approach where the clients focus on the emotions and cognitions that arise when they recall a traumatic situation as they follow the back-and-forth motions of the therapist's finger that alternatively stimulates the right and left hemispheres of the brain (Leeds, 2009). More recently, other forms of bilateral stimulation, such as auditory tones and other electronic devices are commonly utilized.

Expressive arts therapy has a totally different history of creative development than the other therapies in this book. Art, music, drama, dance, and poetry have been used throughout the history of humankind as a method for individuals and communities to heal from emotional pain. The contemporary field of expressive arts therapy was created in the 1970s by Shaun McNiff and Paulo Knill at Leslie College in Cambridge, Massachusetts, with later important contributions by Natalie Rogers (Leslie University, 2023; Malchiodi, 2020).

As traumatic experiences are encoded in the brain as memories in the form of imagery and bodily sensation, this modality can be an invaluable approach to the integration of traumatic experiences (Gantt & Tripp, 2016).

It is important to note that two major schools of psychotherapy approaches are not considered to be experiential by the editors of this book: *Humanistic therapies* and *third wave cognitive behavioral therapies*. Humanistic approaches, such as person-centered and existential psychotherapies, have been included as experiential modalities by some authors (Watson et al., 1998). These therapies certainly emphasize the clients' perceptions of their existence and the development of an authentic partnership between therapist and client. However, they tend to focus more on discussions of content related to the client's reality, rather than attending to the moment-by-moment tracking of the client's total mind and body perceptions in the room.

Some might also consider third wave cognitive behavioral therapies that focus on mindfulness and acceptance of one's negative thoughts and difficult emotions, such as dialectical behavior therapy (DBT), acceptance and commitment therapy (ACT), and mindfulness-based cognitive behavioral therapy (MCBT), to be forms of experiential treatment. Whereas mindfulness certainly includes a strong focus on the client's whole-body experiences in the moment, the emphasis of these therapies is directed more toward teaching clients skills in order to live a more fulfilling life and less on experiential therapies' focus on the innate healing process of self-discovery of the client's inner world in the context of an authentic healing relationship with the therapist.

Whereas the purpose of this book is to demonstrate how the different experiential psychotherapies can be useful in the treatment of trauma, it is not the intent of the editors to claim that these forms of therapy are necessarily the preferred treatment for those suffering from the aftermath of trauma. There are certainly a wide range of therapies with a significant evidence base for treating trauma, including different forms of cognitive behavioral therapy, exposure therapy, dialectical behavior therapy, and narrative therapy. Every human being is different, and what works for one person may not necessarily work for someone else. However, it is hoped that the reader of this book will gain an understanding of the unique contribution that experiential therapies offer for those suffering from post-traumatic difficulties.

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