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Putting the Pieces Together: 25 Years of Learning Trauma Treatment

By Janina Fisher

I now realize that, back in 1989 when I began my clinical internship in a big city hospital, most of our patients---everyone from university professors to working-class families to the homeless and chronically mentally ill---were suffering the effects of some unrecognized traumatic experience. I say unrecognized because, back then, we only connected the word *trauma* to combat veterans or victims of sexual violence. It had been only 15 years since the opening of the first rape crisis center and just nine since post-traumatic stress disorder (PTSD) had become an officially recognized DSM diagnosis. Trauma, in fact, was still defined as "an event outside the range of normal human experience." We didn't yet know to ask all clients about early abuse or trauma, still unconditionally accepted the idea that the uncovering of buried memories was the key to setting trauma sufferers free. As descendants of Freud, we believed that the therapist's role was to remain neutral and say as little as possible while the patient free-associated---until the time came for the "right" interpretation or the always handy question "How do you feel about this?"

By the early 90s, however, *The Courage to Heal*, a feminist-influenced self-help book by Ellen Bass and Laura Davis, had become a huge bestseller. Bringing public attention to the previously taboo subject of childhood sexual abuse, it

proposed a dramatic approach to trauma treatment that was a far cry from the strict neutrality prescribed by psychoanalysis. In essence, Bass and Davis saw the main task of trauma work as retrieving the missing pieces of the abuse narrative, however dimly it might be recalled, and encouraging victims to confront the perpetrators with "their truth." As a fledgling therapist who had never felt comfortable just nodding sympathetically in response to someone's horrible tale of a trauma experience, I was relieved by the permission this approach gave to be more actively engaged with my clients.

At the same time, I was troubled by what *The Courage to Heal* model required of my clients: focusing on accessing their anger at the perpetrators or neglectful bystanders and holding them accountable through confrontation. While most therapists applauded the visibility this gave to the long-neglected issue of sexual abuse and its support for survivors becoming more vocal and empowered, at the hospital where I worked we were seeing some dangerous after-effects of this approach. Many clients became overwhelmed by the flood of memories that came once Pandora's box was opened, and others began to doubt themselves when they couldn't access memories. Worst yet, family confrontations frequently ended in retraumatization for the victim. Defensive or in denial, many family members refused to believe the disclosures and even turned the tables on survivors by leveling accusations like, "You're destroying this family!" Rather than finding support, our clients often found themselves becoming family outcasts.

During this paradigm shift in the trauma treatment world, Judith Herman, who'd published *Father-Daughter Incest* in 1980, was working as a staff psychiatrist

at Cambridge Hospital in Massachusetts and establishing a special clinic called the Victims of Violence Program. In the broader mental health world, few people knew of Herman's book, her clinic, or the research she'd begun on the relationship between borderline personality and childhood abuse. Even after the release of her groundbreaking *Trauma and Recovery* in 1992, it would take several years for her ideas to catch on.

Still, Herman was convinced that there was something deeply amiss and destabilizing about the confrontational tactics recommended by Bass and Davis. She believed that good trauma treatment required a much more patient approach, delaying the focus on traumatic memories until survivors felt safe in their daily lives and had sufficient affect regulation to tolerate the stress of remembering dark episodes in their histories. A political feminist, she argued that victims needed to feel empowered not only in relationship to their peers and partners, but also to their own memories. To her, the idea of feeling overwhelmed and overpowered by the remembering process was antithetical to the resolution of trauma. Although today the word *retraumatization* is used routinely by mental health professionals and *stabilization first* has become the gold standard of trauma treatment, at the time, these were new ideas.

Also new was Herman's insistence that the power imbalance of the therapeutic relationship was exacerbated by therapists' keeping to themselves the growing literature about PTSD, its treatment and the course of recovery. She believed that therapists must become educators, providing information that made sense of the client's symptoms and helping them to understand their intense

reactions as survival adaptations to a dangerous and coercive childhood environment. Herman's idea that knowledge is power resonated deeply with me, as did her perspective on *The Courage to Heal* model that premature memory retrieval and disclosure could be harmful to many clients. Telling their stories of abuse was emboldening only when clients could tolerate the overwhelming feelings that it was likely to trigger; and confronting the family, if it ever took place, could wait until they no longer needed anything from them.

Just how revolutionary the idea of stabilization was in the early 1990s is illustrated by my meeting with a young client named Ariana back in the day. Despite a long history of childhood sexual abuse and many attempts to get help, she hadn't been able to tolerate therapy for more than a few months. Since she seemed to be the ideal therapy client---bright, insightful, and articulate---I was curious about why this was so.

"What told you in each of your experiences with therapy that it was time to leave?" I asked.

"Well, that's easy," she laughed. "Either the therapists wanted to make me cry---or they wanted to move in for the kill!"

"The kill?" I asked, confused.

"The kill is when they say, 'Next week, we can begin to address the trauma.'"

She's right, I thought. In those days, most trauma therapists would've wanted a client like Ariana to cry as evidence that she was "in touch" with her emotions, and most assuredly they would've wanted to help her tell her trauma story. Even among

the converted at Herman's Victims of Violence Program, the pervasive view was still that stabilization was just a prerequisite for the "real" trauma work.

It seemed to me, however, that stabilization wasn't just a dress rehearsal for the "important stuff." Instead, it gave clients back their lives, offered them a meaningful present as an alternative to reliving the past, and was invaluable in their learning to tolerate their often volatile emotions. After all, shouldn't traumatized clients have the power over the remembering process and the right to remember more or to remember less? And why was the ability to function and build a new life a less honorable task than memory work? Although the mid-80s to mid-90s offered a promising start in a field that was still relatively new, it would take the next phase, the neuroscience revolution, to explain why remembering the past was not the centerpiece of the trauma recovery process.

Busting the Monopoly of Talk Therapy

Neuroscience was brought into the field of trauma by the outspoken and sometimes controversial psychiatrist Bessel van der Kolk. Ever since his work with the Veterans Administration (VA) in the 1970s put him on the path to studying trauma, van der Kolk had begun to challenge the conventional psychiatric framework of trauma treatment. Even though the VA showed a marked lack of interest in studying the effects of "shell shock" on veterans, his curiosity and crusading spirit led him to explore trauma in ways that more cognitively-focused researchers tended to ignore.

When I started working on van der Kolk's clinical team as a new supervisor in 1996, he'd been arguing for years that traumatic "memory" included not just

images and narrative, but also intrusive emotions, sensory phenomena, autonomic arousal, and physical actions and reactions. Sitting on Bessel's team, I had a weekly front row seat to his determination to change the way the field approached trauma treatment. In 1994, when his paper "The Body Keeps the Score" was published in the *American Journal of Psychiatry*, the message that trauma often lives non-verbally in the body and brain was a source of tremendous discomfort in a field that did not yet recognize body-based treatments as reputable. However, the advent of brain-scan technology allowed van der Kolk to conduct the research needed to support his arguments. His findings laid the groundwork for an alliance between traumatologists and neurobiologists that challenged the reign of talk therapy---an alliance that has since impacted all therapists, not just those in the trauma treatment field.

In van der Kolk's 1994 groundbreaking study, 10 subjects volunteered to remember a traumatic event while undergoing a brain scan. As they began to recall these events, the PET scan revealed a surprising phenomenon: the cortical areas associated with narrative memory and verbal expression became inactive or inhibited, and instead there was increased activation of the right hemisphere amygdala, a tiny structure in the limbic system thought to be associated with storage of emotional memories without words. These volunteers had begun the scan with a memory they could put into words, but quickly lost their ability to put language to their intense emotions, body sensations, and movements.

No wonder our clients were having such difficulty putting their experiences, even present day ones, into words. No wonder they had difficulty remembering the

past without becoming overwhelmed. Psychotherapy from the time of Freud had been premised on the assumption that putting words to one's emotions and painful past experiences would set us free, but this research (and the many replications since) told a different story. If the experiences are traumatic, if the emotions exceed the affect tolerance of the client, then the parts of the brain needed for differentiating past from present go "offline" and become inaccessible. Retraumatization now made sense. If we purposefully or inadvertently trigger old traumatic responses, brain areas responsible for witnessing and verbalizing experience decrease activity or shut down, and the events are reexperienced in body sensations, impulses, images, and intense emotions without words.

"This changes everything," I remember thinking when Bessel first described his findings, and it did. Accustomed to using words as the primary treatment tool, talk therapists had to find other approaches that weren't so dependent on language and narrative, ones that could address the brain and body shutdown demonstrated in van der Kolk's study.

Van der Kolk has been instrumental in bringing greater visibility and credibility to a new cadre of nontalk treatments, including eye movement desensitization and reprocessing (EMDR), sensorimotor psychotherapy, somatic experiencing, internal family systems, yoga therapy, and neurofeedback. Though each was known prior to his interest in them, his flair for polemic and drama brought heightened attention to them, emphasizing their distinctive neurobiological impact. EMDR, in particular, expanded our notions of what constitutes effective psychotherapy in those early years. Developed and extensively researched by

psychologist Francine Shapiro in the late 80s, EMDR uses bilateral eye movements, tapping, and other forms of bilateral stimulation to help clients process traumatic experiences. Like van der Kolk, Shapiro was convinced that PTSD was the result of the brain's failure to digest traumatic experiences. However, because of its unconventional, finger-waving method and a lack of support from other researchers at the time, EMDR seemed more snake oil than legitimately therapeutic to many skeptics in the field. In fact, it's embarrassing now to recall the advice I gave a member of my Mothers of Incest Survivors group in 1993 when she asked whether I would recommend EMDR for her daughter. "Oh no," I said. "EMDR is too woo-woo. I wouldn't recommend something like that." Two years later I found myself at my first EMDR training weekend. Caught up by the fervor of a field in search of new discoveries, I was willing to try this approach that was so strongly championed by van der Kolk, a former skeptic himself. Given that up to this point straightforward therapeutic approaches had demonstrated such limited ability to alter the effects of trauma, why not try something different? To my amazement, during that first training weekend, my first practice client overcame a phobia of riding escalators dating back to childhood in our 20-minute session. When she hugged me, thanked me effusively, and went off to take a victory ride on the escalator at a nearby mall, I knew I'd been wrong about EMDR. .

By the early 2000s, news of EMDR's success had been commonly noted in popular newspapers and magazines in print and online. Soon I was returning phone calls to potential clients who'd learned about EMDR on their own and were seeking it as their treatment. Judith Herman's wish that survivors empower themselves with

information that can help to set them free was coming to fruition. But EMDR spurred another revolution as well---one in the therapist. Once EMDR-trained therapists became accustomed to methods outside their habitual treatment frame, it suddenly seemed like a logical next step to learn other approaches that also involved something more than sitting in a chair, listening, and talking. Millions of therapists around the world have subsequently become open to using new treatments that were different from the "talking cure." Each of these new approaches validated my thinking that the answer to trauma recovery wasn't to be found in reliving the past but in having a different experience of the present. They also confirmed my belief that trauma treatment shouldn't have to hurt too much. Despite the long-held assumption in the field that effective trauma work must involve staring down one's personal Godzillas, it never felt fair to me for the treatment to be as painful as the effects it was treating, or for my traumatized clients to have to suffer all over again to be well.

How Neuroscience Changed Psychotherapy

The idea that the neuroscience research could be germane, even necessary, to psychotherapy began as a seed planted by van der Kolk to help survivors of trauma understand how their bodies tended to perpetuate post-traumatic reactions. With the publication of works such as Allan Schore's *Affect Regulation and the Origin of the Self* in 1994, Joseph LeDoux's *The Emotional Brain* in 1996, and Daniel Siegel's *The Developing Mind* in 1999, the world of science began to inspire new growth in the field of psychotherapy. Each of these experts challenged the primacy of the mind

as the basis of human emotional life, bringing attention to how the brain affects our capacity to use our minds. Each argued that not just social-emotional development but the slowly maturing brain and nervous system could be dramatically and perhaps permanently affected by early attachment relationships, neglect, and trauma. Still the question remained as to how to translate this new understanding of how the brain and nervous system worked into clinical practice.

As increasing numbers of therapists read LeDoux, Schore and Siegel, the vocabulary and perspective in the therapy field began to enlarge and shift. Whereas we once believed that the symptoms and behavior exhibited by our clients were a reflection primarily of their psychological defenses---a view that attributed a degree of intentionality no matter how unconscious---now, we better understand the symptoms as manifestations of instinctive brain and bodily survival responses. We understand that sympathetic activation fuels anxiety and rage, parasympathetic dominance causes shutdown and passive-aggressive behavior, flight responses spur fleeing the therapist's office, and fight responses lead to verbal or physical aggression or violence turned against the self. When clients self-harm, for example, these days, we understand their actions to be instinctive rather than thought out, an effort to regulate or relieve rather than punish.

The case of Jessie illustrates my own education and how neuroscience came to guide more and more of my clinical work. Jessie's long history of suicide attempts, hospitalizations, and dramatic deteriorations in functioning challenged everything I thought I knew about treating trauma up to this point. Some weeks, she disclosed childhood memories of a mentally ill, terrifying mother who tormented her; the next

week, she'd look confused or annoyed, snapping, "I never said I was abused!" Between sessions, she'd email me with desperate pleas to help her, but often came to therapy professing boredom and a lack of anything to talk about. She'd vigorously deny suicidal impulses and then call me hours later to say that she'd just taken a whole bottle of pills.

As I pieced these contradictory bits of evidence together, I realized that although she may not consistently have "remembered" being traumatized, her body and nervous system were being constantly activated by the simple challenge of maintaining a consistent sense of selfhood from day to day. Ordinary interaction with coworkers, clients, neighbors, friends, family, and even her therapist propelled her into extreme, alternating states of both longing and fear, a desperate wish to trust and a fierce determination to avoid trusting at all costs. She declared her opposition to most of my therapeutic tools and refused to talk about trauma or dissociation, try EMDR, or "do that stupid body stuff." I didn't know whether to rush in or hold back, empathize or hold my tongue. At a loss, I turned to Schore and LeDoux for help in understanding Jessie in a different way.

According to LeDoux, Jessie's amygdala---the part of the brain that scans for danger and initiates the stress response system---had undoubtedly become "irritable" in the context of growing up with a frightening mother, nonprotective father, and equally helpless siblings. Schore's work went further to help me think about her suicidality as a problem in affect regulation rather than a wish to die. With a dysregulated nervous system and a coping toolbox limited by her childhood, her ability to soothe and regulate emotions was minimal. She often ran from the stresses

of her job, hid under the covers, and fought for control over her feelings by planning her death. The affect associated with even acknowledging her traumatic experiences dysregulated her nervous system and set off false alarms in her amygdala, shutting down or hyperactivating autonomic arousal, and interfering with her ability to self-observe and think clearly.

My reading of Schore encouraged me to become more of a "right brain to right brain" interactive neurobiological regulator. Rather than using words, logic, or interpretation of the connections between emotions and triggers, I'd intuitively base my response on her response. This meant noticing my own words, tone, and body language, then observing her nonverbal and verbal reactions, then slightly modifying my next communication to heighten what seemed to be creating more connection or interest in her or to change a way of speaking that shut her down more or evoked irritability.

I began to work more creatively with Jessie. Instead of linking past events to her present distress or trying to help her learn skills for regulating overwhelming feelings, I concentrated on just two goals: not activating her amygdala in session and using my voice and body language to soothe and regulate her nervous system. For instance, when she'd fold her arms and announce, "I have nothing to talk about today," I'd chuckle.

"Why are you laughing?" she'd ask irritably.

"Because there's always so much to talk about," I'd respond, chuckling some more. "That's just too funny."

A little smile would curl on her lips as long as I was amused rather than dysregulated by her attempts to shut me down.

When she'd say, "You can't help me," I'd let my arm drop onto the arm of my chair in a reaching out gesture and just leave it there. Indeed, I noticed that she seemed calmer when she saw my slightly outstretched arm, and sometimes I'd even call attention to it, saying, "Look at this---even my arm is wanting to help." Somehow it was regulating for her. I didn't try too hard to help (because that would dysregulate her), but I made sure that she could see the message held in the gesture of my arm.

Rather than trying to convince her that there was trauma at the root of her difficulties, I began to simply comment about how much her parents had struggled---and that soothed her enough to articulate her dilemma. "I love them," she said, "but even a short visit can unglue me for weeks. I don't know why."

Instead of giving in to my impulses to tell her why, I tried to evoke interest without investment in the answer. Just to keep her medial prefrontal cortex online, I'd say, "Well, we can just be curious about that, huh?"

That year, although Jessie never wavered from her stance about what we could and couldn't talk about, she made no suicide attempts and was more stable in sessions. Although I didn't realize it at the time, I was becoming a body-oriented therapist---using my body to communicate, not just my brain.

The Contribution of Somatic Psychotherapy

In 1999, I was still working in van der Kolk's clinic when his motto became "Go to the body!" If trauma-related symptoms were driven neurobiologically, he argued, if the problem wasn't so much the traumatic events as it was the legacy of autonomic and bodily responses fueling intense emotions, numbing, or confirming distorted beliefs about the self, then as a field, it was imperative that we find ways of working with the body. Personally, however, I resisted undergoing any body-centered psychotherapy training. I maintained that I'd never a study a therapeutic approach that required touch---an incorrect conflating of body therapy and bodywork.

At the same time, I knew that there were clients and places inside them I couldn't reach with my existing repertoire, so, in spite of myself, I signed up for Pat Ogden's training on sensorimotor psychotherapy after watching in awe her videotapes of clients resolving trauma without becoming overwhelmed and not just with tears but also laughter. Slowly, I came to understand that a body-centered psychotherapy was less about touch and more about how to work effectively and sensitively with emotions and cognitive schemas. Counter to the training I'd received when I began my career, I learned to interrupt clients to ensure that they didn't become dysregulated and overwhelmed. Plus, I learned to use Rogerian mirroring to deepen their ability to listen to themselves. Most intriguing to me, however, was that each element of sensorimotor psychotherapy had a specific brain-based goal. Interrupting and remaining in vocal contact, for example, was intended to not only help the client feel "met," but to regulate autonomic arousal and keep the prefrontal cortex online. In addition, mirroring and repetition was meant to activate trauma-related neural networks so they could be reorganized

through experimentation with alternative responses to create a different present-moment experience.

The basic tenets of treatment involved evoking just enough of the narrative to activate implicit memory, asking the client to pause and be curious, and then mindfully attend to how sensations, movements, thoughts, and emotions unfolded until we could sense what the body "wanted to do" now. With what SE developer Peter Levine calls a " bottom-up approach," the narrative could simply be the narrative of how someone felt in that moment, not necessarily a trauma narrative.

This new understanding further enhanced my work with Jessie. Now, although I continued to chuckle whenever she said she had nothing to talk about, I went on to ask her, "When you say, 'I have nothing to talk about,' what happens inside? Do you feel more open or closed? Do you pull back a little? Shut down?"

"It's more like a wall," she said.

"Interesting. A wall in your chest, your abdomen, or both?" I asked.

"It's all the way down my front."

"Like armor?"

"Yes." Jessie seemed deeply engrossed in this moment.

"And is it a familiar feeling?" I continued gently.

"Oh, yes! I get it with anyone who gets close to me. When I'm wishing to get to know them or wishing they'd like me, it's not there, but when they get closer, when they want something from me, the wall goes up."

"How clever," I said. "So your body created the wall to protect you from people who want things. That's brilliant! Let's just be curious about how it works,

how your body knows when people want things." I noticed that as I reframed the wall as a helpful tool, she looked more relaxed---and eager to keep talking. She was no longer that person who had "nothing to talk about." Instead, she told me in great detail how the wall helped her keep a poker face in her professional career as a demographer, but how it also confused her friends.

"Yes," I agreed, "the wall sometimes confuses me, too. Which is great---that means it's doing its job." At this point, we both laughed. Rather than letting the wall dominate her therapy and other close relationships, Jessie was learning to be aware of it, to "hang out" with it, and be interested in its role in her life.

The Mindfulness Revolution

Over the past decade, thousands of therapists and clients have taken up meditation to bridge mindfulness practice with the relational and practical challenges of psychotherapy. Mindfulness is inherently a practice of "being here now"; the past is only of interest as it arises and intrudes on present moment experience. In contrast, the hallmark of PTSD is being trapped in the past, experiencing fear, rapid pulse, butterflies, rage, tightness, impulses to run or hurt, and humiliating and punitive thoughts not as a reaction to what's occurring in the present but as a consequence of overwhelming experiences in the past. Without a way to understand these responses as "memory," our clients experience them as data about who and where they are *now*.

While the neuroscience world gave us the beginning of a scientific explanation for understanding PTSD, mindfulness offers a way for clients to change

their relationship to the darkness of the past. Mindfulness is inherently about relationship: how we relate to our bodies, beliefs, and emotions. In other words, when Jessie became interested in her wall as expressed in the body sensation of armoring and the words, her relationship to it changed and she became less attached to maintaining it and more to understanding how it served her, both good and bad. That change in her relationship to the wall spontaneously changed our therapeutic relationship. From my end, rather than seeing her wall as an impediment to the "real work" of therapy, I could appreciate the way it had protected her from a frightening mother who alternately clung to her and attacked her in a rage. But using a mindfulness framework, I didn't have to name the connection to the past. I simply had to notice my associations to her past as my own and then, along with her, appreciate the here-and-now process of getting to *know* the wall. Jessie and I were doing trauma treatment, not by exploring the past, but by reorganizing her relationship to the past. Gradually, the wall softened, and when it became rigid again, it was easier for both of us to be curious, to find it interesting rather than frustrating.

I now ask clients to take a more accepting, Buddhist approach to their present and past experience, avoiding their usual habits of attachment or aversion, discovering how to build new habits of nonjudgment that, with sufficient repetition, evolve into increasing self-compassion, or at least neutrality. In this way, the mindfulness movement has been a practical extension of the neuroscience revolution which has shown us that mindful concentration activates the medial

prefrontal cortex, decreases activity in the amygdala, which, in turn, facilitates regulation of the autonomic nervous system.

Helping clients heighten curiosity and interest rather than automatically descending into shame and self-blame is a slower process than helping them tell a story, describe a problem, or even devise solutions. It may feel to both therapist and client that not much is going on, yet research on neuroplasticity tells us that focus, concentration, and repetition of new responses to traumatic phenomena can help us encode new neural networks that, side by side with the memory networks associated with trauma, allow us moments of peacefulness, well-being, and even joy. Mindfulness has also introduced the psychotherapy community to the revolutionary idea that, rather than painful, dark emotional states being seen as the source of healing, positive states of mind and body may be what is truly necessary for the healing process. In mindfulness practice, positive states are cultivated instead of being interpreted as a defense against grief, anger, resistance to trauma processing, or denial. If positive states don't arise spontaneously, mindfulness-based therapists can help clients induce them by focusing on phrases that cultivate bodily sensations of well-being ,such as "May I be filled with loving kindness. May I be safe from inner and outer dangers. May I be well in body and mind. May I be at ease and happy. May I be free of suffering."

Often difficult at first for trauma survivors simply to utter, such meditations often increase clients' ability to tolerate peacefulness and well-being. But we shouldn't let that discourage us. Neuropsychologist and therapist Rick Hanson in his best-seller *Hardwiring for Happiness* cautions clinicians to beware of what he

calls the “negativity bias,” the tendency of the human brain to preferentially attend to negative stimuli, scan for danger rather than pleasure, and encode negative experiences more rapidly and permanently than positive ones. Hanson warns that if we don’t attend to and install positive experiences in psychotherapy, the brain’s “net will automatically keep catching negative experiences.” Twenty five years ago, who would have thought that the experience of joy had a place in trauma treatment!

We’ve come a long way in the past 30 years. We began with the belief that excavation of the dark and unspeakable horrors would set trauma survivors free, and, in so doing, we brought greater awareness to what happens in wartime to soldiers, what happens to women and children when they’re victims of violence, what happens in a natural disaster that destroys lives and homes. But now, we’ve changed our focus from the dark to the light. In fact, in this new age of trauma treatment, we aim to help our clients find the light---or at least to find their bodies, their resources, and their resilience.

These days, we’re interested in so much more than the grim story of what terrible things happened in the past. Of course, listening and witnessing to the clients’ experience are still central to the treatment process, but we focus now on much more than the traumatic events in our clients’ history, knowing events can’t truly define who they are. Instead we’ve also learned to give weight to our clients’ attachment experience, to how their brains and nervous systems work, their ability to notice rather than judge, their appreciation of what it took of them to survive life’s setbacks, and increasing their capacity for noticing what’s happening in their

bodies as the primary pathway for staying in tune with the present moment. In contrast with 25 years ago, the trauma treatment of today focuses survivors not primarily on pain but also on accessing new, more expansive feelings, the kinds of feelings they would have experienced had they never been traumatized. As I often say to my clients, the goal of therapy is simply helping them reclaim their birthright, the basics to which all children are entitled: a sense of safety, welcome, and well-being.

This is the new world of trauma treatment, one we could never have envisioned thirty years ago.

What will happen next? The fact that strong disagreements about approach still exist seems to be a sign that there's still more work to do in our field. Perhaps, however, our challenge now should be to educate the general mental health world about the prevalence of trauma, overcome stigmatization of the trauma-related disorders of borderline personality and bipolar II, and win credibility for the new approaches emerging from the trauma treatment world so that even the "worried well" have access to them. Maybe the next frontier will be changing culture rather than healing individuals. Stay tuned. . . I know I will.

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