Trauma Blocks the Frontal Lobes – “Verbal Physiotherapy” Can Unblock Them

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By Bob Johnson, MD

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Medically speaking, the DSM is unfinished business. That’s the polite version — there’s worse. *“The DSM authorises slipshod or substandard medical practice”* is a more realistic verdict, which medical editors cannot stomach. The way the DSM is set up, medically, means it cannot staunch the two running sores in today’s psychiatry, namely: (1) Why does trauma continue to inflict damage, decades later? And (2) Why does trauma make the frontal lobes and the speech centre go off-line?

I’ve just sent off five papers to established medical journals in as many months, covering the above points — all perfectly feasible, well-referenced and cogently argued. All five have been rejected with fatuous or unprofessional comments — medical tunnel vision, in spades. In 2003, I reviewed Robert Whitaker’s book *Mad In America* for *New Scientist*, having been awed by it. Since then, I’ve watched in growing dismay as my favourite medical specialty continues to shoot itself in the foot.

You think I exaggerate? Can it really be that bad? Check out the latest news. On Monday, 23 July 2018, *The Guardian* reported, under the heading “Sexual assaults — Link to mental illness”:

“Four out of five teenage girls who have been sexually assaulted are suffering from crippling mental health problems months after their attack, research has found. . . . Experts said the findings had confirmed that becoming a victim of abuse in childhood could lead to mental health issues, **which could last a lifetime**.” [emphasis added]

“Hello, Teenage Girl, I’m sorry to hear you’ve been sexually harmed. I am such a skilled expert in psychiatry that I can assure you, you will be damaged by this single event for the rest of your life.” If that doesn’t make your blood boil, just a little, something’s amiss.

This is running sore number #1 from above. It would seem to any normal doctor, and to everyone else, that any mental symptom afflicting these teenage girls comes as an obvious “reaction” to sexual harm. Not so, if you’re a DSM-doctor — this simple connection is explicitly *not* permitted under DSM rules. On page xvii in the DSM-IV, we find: “DSM-II was similar to DSM-I but eliminated the term *reaction*.” This runs directly counter to clinical reality — the whole of non-psychiatric medicine relies precisely on finding just what the present symptoms are a *reaction* against. Incidentally, DSM-II, for those who bother to check, is replete with “reactions.”

An Aetiological Vacuum

Which leads on to aetiology, medical-speak for "causative factors." How can you possibly hope to do any good, medically, if you declare a blank non-interest in what brought this illness on? "You've a pain in your leg? My psychiatrist's bible instructs me not to ask if you recently fell over." Again, you might think I exaggerate, but check out page xvii, in DSM-IV: *"DSM-III introduced a number of important methodological innovations, including . . . a descriptive approach that attempted to be neutral with respect to theories of etiology."* Thereby wantonly sabotaging millennia of medical practice, since before Hippocrates. This approach couldn't last microseconds in all other branches of medical practice, where ameliorating causative factors is the be-all and end-all of what doctors seek to do. Ask any non-DSM doctor.

I was a family doctor for 20 years, and the chief delight there is puzzling out, in the best Sherlock Holmes manner, which of the preceding events mattered most in bringing on any given medical problem. Digging that bit deeper, asking the unexpected, uncovering unacknowledged causes, all these add grist to an ever-growing medical skill, but not if you slavishly follow the DSM dogma — a dogma which "neutralises" aetiology. Is this substandard medical practice or what?

How can you expect to link sexual harm to psychiatric pathology, if you are debarred, by the DSM, from exploring aetiology? It sounds ridiculous even to suggest such a thing, and non-DSM doctors would find it hard if not impossible to believe — but there is it in black and white, and confirmed by the painful fact that running sore number #1 (Why does trauma continue to inflict damage?) continues unabated.

One of the five medical papers I've recently had rejected (April 2018) was based on a tight textual analysis of the differences between the ICD-10 and DSM-IV. A high court case turned, legally, on these differences, which meant I needed to rehearse them well enough to be able to explain them to a non-medical jury. This is why the page references here are to DSM-IV. DSM-III and DSM-5 are much the same.

Ordinary Physiotherapy & Patient Agency

The third gross medical flaw in the DSM was a bit of a challenge to convey in terms a jury could readily pick up. This is because it is quite impossible to define scientifically. It goes by the medical term "Patient Agency" — it's what the patient does, believes, chooses, thinks. It can get all tangled up with philosophical arguments over free will and such. But again, it is 100% indispensable in any medical practice. If the doctor doesn't chime in with what that particular individual opines, then medical progress is likely to be slow.

DSM-IV doesn't even bother to debate the issue, but buries it behind a wodge of shallow sophistry on page xxi, where dust is thrown in the reader's eye by way of such obfuscations as "body-mind dualism" and "problems raised by the term 'mental'." So let's move promptly into something entirely uncontroversial — physiotherapy. Drop in on any physiotherapy clinic anywhere in the world, and you'll find sturdy physiotherapists actively, and enthusiastically, engaging with Patient Agency.

Try imagining physiotherapy without it. Instead of "Try that bit harder, you can move your arm a little bit further" you'd be talking to yourself. And the patients in your care would stultify. You cannot have physiotherapy without Patient Agency. Nor can you, in my 60 years medical experience, have any other clinical practice without it either. How the DSM thinks it can get away with trying to do so, beats me.

So what would you think if, instead of the current wide gamut of psychiatric "treatments," you had something which only worked if the sufferer knew what you were trying to do, and then engaged their "will power," or Patient Agency, or whatever else you like to call it, to do it? It stands to reason, if you want the person in front of you to think differently about their problem, then you have to engage with what they think, and thereafter, what they'll do, i.e. in their Patient Agency. A point even more vital in mental healthcare than anywhere.

Which leads us to Dr. Bessel van der Kolk. Way back in 1996, in his book *Traumatic Stress* (page 193), following groundbreaking work with traumatised people, he coined the telling phrase "speechless terror." Look at that term. Here *terror* stops you from *speaking*. Is that significant? Does it apply more widely?

In a recent video Bessel calls this having a stroke. I call it a trauma-stroke. He gives us the wonderful notion that trauma makes the frontal lobes and the speech centre go "off-line." So look closely at what he did. He played an audio tape of music, say, to someone whose brain he was scanning, and all was well. He then played a tape of the gunshot, the car crash, whatever that traumatic event had been, and to his surprise, and my delight, the frontals and Broca's area of the brain (which is linked to speech production) no longer worked — they shut down.

I put this evidence centre stage. This is the one and only brain scan evidence that applies universally in psychiatry. The mind is difficult to read at the best of times, and impossible to read with a machine, so here we have something scientific, something objective, something available to anyone with the right equipment: trauma stops you from thinking straight. What could be more obvious? Stops you from *talking* straight — is that a serious issue for clinical personnel? I should say so.

Running Sore Number 2

Of the two running sores which currently afflict today's psychiatry, the most injurious is the observable fact that all past events fade from memory, in the ordinary way, except the worst aspects of trauma. Why does the gunshot still ring in the head, the car keep crashing, the rape keep recurring — all in the head, no longer in reality — even decades later? Why? What can possibly account for such pathological remembering?

Just pause for a moment and consider how ordinary medical consultations proceed. The patient tells the doctor what's been going wrong, and the doctor works out what's best to do about it. See that verb, "tells." What if the speech centre is "off-line"? What if the words simply don't come out, just as happens too often with ordinary "strokes," or cerebro-vascular-accidents (CVAs). What then? Trouble, that's what.

So this is the number one reason why talking about abuse is so difficult: *the words are blocked*. Being a family doctor for so long, I was able to study childhoods, untrammeled. Thus in 1986, I asked a woman I'll call Grace to address an empty chair on which we'd agreed to place an image, a memory of an abusive parent. "Hello parent, I'm an adult." I knew enough by then to invite her to say that. Guess what? She couldn't. I was astonished. She then turns to me, and repeats these words verbatim — no problem there. On turning back to the empty chair, her mind went blank — no words would come out. Frontals off, frontals on, within seconds. You can be sure this was a wowee moment. (Don't try this at home — a prisoner threatened to garrote me, because I went too fast. Beware!)

This is where Bessel's frontal blockages show themselves in practice. He proved they exist by obvious, objective, mechanical brain scans. Grace, and so many others, confirm their impact, clinically, by their selective speechlessness. Talking about trauma runs up against speechless terror — the terror from long ago stops speech today. Not an easy point to pick up. But Bessel's brain scan work is irrefutable. Anyone can repeat it, any time — something you can rarely say about any other psychiatric evidence.

So if you reclassify trauma effects as trauma-strokes, and you adapt physiotherapy to take this irrefutable clinical evidence into account, then you come up with Verbal Physiotherapy — at least I do.

Now, I'm not going to tell you I've solved running sore number #2 — why the frontals go off-line — except to say that the abused child adopts a psychological defence: "This isn't happening to me." Whereupon in later life, it is hard to reverse that and say, unequivocally, "This has stopped happening to me." The circumstances pertaining to such a reversal have to be utterly different from those prevailing at the time of the trauma, something which is often surprisingly difficult to achieve.

In fact, what is so astonishing about running sore number #1 is that the pain remains to such an extent that it blots out many earlier pleasures. Here we have both clinical and brain scan evidence (running sore number #2) as to why — the memory of the trauma is so deeply imprinted, it blocks thinking and speaking about it. Which is why it persists. However, if you are prepared to engage Patient Agency, and can gain wholehearted consent to broach quasi-lethal memories, then you can re-engage both frontals and speech centre — provided all the circumstances are propitious enough (a vitally important proviso).

How "Verbal Physiotherapy" Works

Where better to trial-run this than in a maximum security prison? In 1991, I found myself as a consultant psychiatrist in a Special Unit for violent, unstable, ill-disciplined lifers in Parkhurst Prison on the Isle of Wight. If it worked there, it'd work anywhere.

Start with Exhibit One: I asked the prisoners, “Why did you murder?” The verbal “answer” from the 60 murderers I got to know well was a blank — their frontals and speech centres were “off-line.” “S/he had it coming,” “a red mist came down,” “I just lost it.” As far from the world of Agatha Christie as you can imagine. There certainly were potent motives for homicide (there always are), but ask the perpetrators what their motive was, and you’ll draw a blank — just as you often will for other victims of Adverse Childhood Experiences. Something happened, something dreadful, but talking about it is uphill work, believe me.

So I put into practice in that prison what I had learned in family medicine: *Sit your abuser down in that empty chair, and tell them they can’t hurt you anymore, because you are now an adult*. Guess what? It took months, even in some cases years for many of the prisoners to be able to do it. “My mother has always been taller than me — and always will be,” one prisoner insisted. “I can’t say the words ‘hello parent, I’m an adult’.”

Verbal physiotherapy works in the same way as ordinary physiotherapy — start with the remaining healthy bits, and grow them, encourage them, empower that Patient Agency to fill out the parts that have been damaged. So as with Grace above, I gently encouraged these damaged prisoners to repeat, “Hello dad/mum, I’m an adult.” Some just couldn’t say the words, others got so angry with me that they threatened to kill me — and threats to kill from convicted murderers who have shown they know how to do it need to be taken seriously. As above, DO NOT TRY THIS AT HOME. There are powerful emotional reasons why those frontals have gone off-line — it takes a lot to convert *homo sapiens* into *homo non-frontalis*.

But gradually over the months, with gentle verbal exercises, persistent consensual explorations, and limitless optimistic enthusiasm coupled with unimpeachable emotional support, those speech centres began clicking over again. Not every time, not with everyone — some were still protesting that at 5 foot 6 inches, they were still “smaller” than their 4 foot 6 inch mums. Some frontals are more difficult to kick-start than others. But after about 18 months, say by late 1992, the number of alarm bells at the prison fell to zero — no violence, no assaults. Verbal arguments, yes, but non-thought-through physical assaults, no. Previously there had been 20 alarm bells a year, and one serious assault every six weeks. By the end, in 1996, there had been none for three years — quite a record for any maximum security wing.

And the Future?

Skepticism is entirely appropriate. All this is bound to sound far simpler in words than it is in practice, as is invariably the case with everything else in clinical work. But it has to be simple, else I can’t understand it — and if you don’t know what you’re doing in medicine, watch out. There are bucket loads of pre-conditions which must be met in full if “verbal physiotherapy” is even going to begin, let alone work. But the same pre-conditions apply to ordinary physiotherapy. Lack of Patient Agency has already been mentioned as a deal-breaker — there are several others which need just as much emphasis, if not more.

And of course, if you swear by the DSM, the "psychiatrist's bible," then you are not even going to start. One point really sticks in my craw — it's such arrant medical nonsense it beggars belief, while leaving "aetiological neutrality" in tatters. Check this out: *"The term 'organic mental disorder' is no longer used in DSM-IV because it incorrectly implies that the other mental disorders in the manual do not have a biological basis."* (DSM-IV page 10) The standard motif in today's psychiatry is "brain insufficiency," thereby cleaving to this supposed "biological" basis for psychiatric ills. Permit me to stand this on its head and say: yes, brain changes do occur, and do underlie all irrational symptomatology — but they are *traumatic* in origin, they resemble CVAs (strokes), and as such remit under physiotherapy (suitably adapted).

Well, I favour the notion of trauma-strokes — it saved my life in Parkhurst Prison. It ties in so neatly with the well-known inability to verbalise what really happened. It answers running sore #1 pretty much 100% — of course you cannot expect dangerous events not to persist if the sufferer is "blocked" from ever thinking they're "finished." Further, the astonishing success that ordinary physiotherapy can routinely achieve with CVAs augurs well for mental recovery, even cure. Once those frontals start working again, as they should, and as they did before the trauma, then mental health blossoms — and is a delight to see.

However problematic "verbal physiotherapy" may appear, there's no way it can begin to see the light of day until DSM-dogma relents. Until then, expect those two running sores to continue — while all the time, a more basic, well-documented approach is "blocked" from publication. Surely we all deserve better mental health care all round — wouldn't you agree?

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Mad in America hosts blogs by a diverse group of writers. These posts are designed to serve as a public forum for a discussion—broadly speaking—of psychiatry and its treatments. The opinions expressed are the writers' own.

Dr. Bob Johnson is a consultant psychiatrist (retired), who trained in both the UK and the USA. In 1967, he refused to give Electric Shock Therapy, which he regarded as akin to the ducking stool and about as effective — whereupon his further psychiatric career was blocked. He spent two decades as a family doctor, and then five years as a consultant psychiatrist in Parkhurst Prison. His book on "verbal physiotherapy" is **How Verbal Physiotherapy Works: Using Social Delight to Defeat Social Harm, for Al**l. https://www.madinamerica.com/author/bjohnson/