The Body Remembers, The Psychophysiololgy of Trauma and Trauma Treatment,Babette Rothschild WW Norton & Company 2000

* Be prepared to brake, slow down or stop the therapy process if the client is showing signs of distress.

**Evaluation and Assessment**

Lenore Terr (1994) has distinguished two types of trauma victims, Type 1 and Type II. Type I refers to those who have experienced a single traumatic event. Type II refers to those who have been repeatedly traumatized.

Two subtypes of Terr’s Type II traumatized individuals should be distinguished: Type IIA are individuals with multiple traumas who have stable backgrounds that have imbued them with sufficient resources to be able to separate the individual traumatic events one from another. This type of client can speak about a single trauma at a time and can, therefore, address one at a time. Type IIB individuals are so overwhelmed with multiple traumas that they are unable to separate one traumatic event from the other.

There is an additional type. This is the client who has many symptoms of PTSD but reports no identifying event(s) that qualify him for that diagnosis. Scott and Stradling (1994) proposed an additional diagnostic category they call prolonged duress stress disorder (PDSD).

**Attunement, Misattunement and Reattunement**

There is a conundrum with some Type IIB trauma clients. Truse in the therapist may gtow following a conflict (a perception or suspicion of betrayal or other type of disruption), provided it is followed by repair of the relationship – misattunement and reattunement. When conflict risk is high, it can be a good idea to prepare the client for periods of perceived injury or betrayal by the therapist. Actual planning for such occurrences can go a long way toward turning them into constructive events.

Another type of misattunement can occur when the client transfers the memory of a perpetrator onto the therapist and becomes afraid in her presence. When this occurs, the therapist must help the client to reality test and separate the two.

**Safety**

The first rule of any trauma therapy is safety (Herman 1992). That applies not only within the therapy setting, but also in the client’s life.

**Developing and Reacquainting Resources**

The more resources the client has, the easier the therapy and the more hopeful the prognosis. … It is advisable to evaluate resources and build those that are lacking before embarking on a difficult course of trauma therapy.

There are five major classes of resources: *functional, physical, psychological, interpersonal* and *spiritual .*

Functional resources include the practical, like a safe place to live, a reliable car, extra locks, etc. In addition, it may be necessary to provide resources in the form or protective contracts with clients during trauma therapy. This idea stems from Transaactional Analysis (Goulding & Goulding, 1997). A trauma client is often confronted with situations that mirror the issues being explored in therapy. It is a mystical, if common, occurrence. The client working on trauma from a car accident has a near miss; the one working on the aftermath of a rape is followed at night, etc. It may be useful to make a contract to pay extra attention to safe driving, or a contract for extra caution at night when working with a client who has been assaulted.

Physical strength and agility are examples of physical resources. For some clients, weight training that increases muscle tone will be beneficial. For others, techniques that drill the body in protective movements, such as self-defense training, will be useful adjuncts to trauma therapy. In general, building physical resources will give many clients a greater feeling of confidence.

**Oases, Anchors, and the Safe Place**

**Oases**

Many trauma clients benefit from engaging in activities that give them a break from their trauma. An oasis must be an activity that demands concentration and attention. For example, knitting, car repair, gardening, computer games or solitaire. Whatever is chosen, its value as an oasis will be recognized through body awareness, by the reduction in hyperarousal as well as quieting of internal dialogue.

**Anchors**

It is preferable that an anchor be chosen from the client’s life, so that the positive memojries in both body and mind can be utilized. Examples include a person (grandmother, a special teacher, a spouse), an animal (favourite pet), a place (home, a site in nature), an object (a tree, a stone), an activity (swimming, hiking, gardening).

**The Safe Place**

It is preferable for the safe place to be an actual, earthly location that the client has known in life. As such, there will be somatic resonance in the memory of it – sights, smells, sounds, etc., connected to that site will all be recorded as sensory memory traces – which will make it highly accessible and useful to the client. The client can imagine his safe place during times of stress and anxiety, or it can be used as any anchor is used, to reduce hyprarousal during a therapy session.

**Ten Foundations for Safe Trauma Therapy**

1. First and foremost: Establish safety for the client within and outside the therapy
2. Develop good contact between therapist and client as a prerequisite to addressing traumatic memories or applying any techniques – even if that takes months or years.
3. Client and therapist must be confident in applying the “brake” before they use the “accelerator.”
4. Identify and build on the client’s internal and external resources
5. Regard defences as resources. Never “get rid of” coping strategies/defences; instead, create more choices
6. View the trauma system as a “pressure cooker.” Always work to reduce – never to increase- the pressure.
7. Adapt the therapy to the client, rather than expecting the client to adapt to the therapy. This requires that the therapist be familiar with several theory and treatment models.
8. Have a broad knowledge of theory - both psychology and physiology of trauma and PTSD. This reduces errors and allows the therapist to create techniques tailored to a particular client’s needs.
9. Regard the client with his/her individual differences, and do not judge her for noncompliance or for the failure of an intervention. Never expect one intervention to have the same result with two clients.
10. The therapist must be prepared, at times – or even for a whole course of therapy – to put aside any and all techniques and just talk with the client.

**Body Awareness**

* *First do not move. Notice the position you are sitting in right now.*
* *What sensations do you become aware of? Scan your whole body: notice your head, neck, chest, back stomach, buttocks, legs, feet, arms, hands.*
* *Are you comfortable? – do not move, yet.*
* *How to you know if you are comfortable or not? – Which sensations indicate comfort/discomfort?*
* *Do you have an impulse to change your position? – Do not do it yet, just notice the impulse.*
* *Where does that impulse come from? If you were to change your position, what part of your body would you move first? – Do not do it yet. First follow that impulse back to the discomfort that is driving it: Is your neck tense? Is there somewhere that is beginning to become numb? Are your toes cold?*
* *Now follow the impulse and change position. What changes have occurred in your body? Do you breathe easier? Is a pain or area of tension relieved? Are you more alert?*
* *If you have no impulse to change your position you might just be comfortable. See which bodily cues you get that signal that you are comfortable: Are your shoulders relaxed? Is your breathing deep? Is your body generally warm?*
* *Next, change your position whether you are comfortable (aagain, if you already did it above). Change where or how you are sitting. Move somewhere else: Try a new chair, stand up, or sit on the floor. Take a new position and hold it. Then evaluate again: Are you comfortable or not? Which bodily sensations tell you: tension, relaxation’ warmth, cold; ache; numbness; breathing depth and location, etc. this time also notice if you are more alert of awake in this position or in the last one.*
* *Try a third position. Evaluate as above*
* *Jot a few notes about your experience, keeping in the language of body sensation: tension, temperature, breathing, etc. “When I was sitting in my chair I felt tense in my shoulders and my feet were warm. When I moved to stand on the floor, my feet became cold and my shoulders relaxed …”*

**Gauging and Pacing Hyperarousal**

Gauging the ANS through observation and the client’s body awareness can increase reliability of the popular SUDS scale (Subjecting Units of Disturbance Scale) (Wolpe, 1969). As its title indicates, this is a subjective measure. The client gives his opinion of his emotional state on a 1-10 scale, 1 = totally calm, 10 = the most disturbed possible. By observing the ANS, both visually and with client feedback on sensory awareness, the therapist secures an additional measure. It is not uncommon, for example, for clients to give a low SUDS rating while hearts race or hands are clammy (sings of high ANS arousel), which might indicate underlying anxiety that is being dissociated in some way.

When observing the client and asking about body awareness, it is fairly simple to evaluate the state of the ANS.

* Relaxed system – primarily moderate activation of parasympathetic nervous system (PNS). Breathing is easy and deep, heart rate is slow, skin tone is normal.
* Slight arousal – signs to low to moderate PNS activation combined with low-level sympathetic nervous system (SNS) activation. Breathing or heart rate my quicken while skin color remains normal; skin may pale and moisten slightly without increases in respiration. Breathing or heart rate may quicken while skin color remains normal; skin may pale and moisten slightly without increases in respiration and pulse, etc.
* Moderate hyperarousal – primarily signs of increased SND arousal: rapid heart beat, rapid respiration, becoming pale, etc.
* Severe hyperarousal – primarily signs of very high SNS arousal: accelerated heart beat, accelerated respiration, pale skin tone, cold sweating, etc.
* Endangering hyperarousal – sings of very high activation of both SNS and PNS, for example: pale skin with slow heart rate; widely dilated pupils with flushed color; slow heart rate with rapid breathing; very slow respiration with fast heart rate, etc.

**Flashback Halting Protocol**

Therapist assertively states: “Look where you are now. What color is the wall here? What color is the rug? What kind of shoes do you have on right now? What is today’s date? Etc.

* Right now I am feeling …………….
* And I am sensing in my body ………….. (name at least three sensations)
* Because I am remembering ………………(name the trauma by title only – no details)
* At the same time, I am looking around where I am now in …………. (year)
* Here …………… (name the place where you are)
* And I can see ………………. (describe some of the things you see right now in this place)
* And so I know ……………. (name of the trauma, by title only again)
* Is not happening any more

The flashback halting protocol can also be effectively adapted for use with nightmares that may be traumatic flashbacks. This has been used as a ritual before sleep, to prepare for the expected nightmare:

* I am going to awaken in the night feeling ………(name anticipated emotion, usually fear)
* And will be sensing in my body ……………(describe anticipated bodily sensations – name at least three)
* Because I will be remembering …………..( name the trauma by title only – no details)
* At the same time, I will look around where I am now in …………….(current year)
* Here ………..(place where you will be)
* And I will see ……… (describe some of the things you see right now in this place)
* And so I will know …….(name trauma, by title only, again)
* Is not happening now/anymore

**Muscle Toning: Tension vs Relaxation**

Chronic muscle contraction underlies what is commonly called “tension.”… Muscle tension has come to be regarded as a foe. It seems no one wants to be “tense”. People spend a fortune for massages, spas, potions to relax, relax, relax. The positive function of muscle tension is rarely discussed.

Muscle tension is taken for granted; it is often regarded with scorn. It is uncomfortable, so how can it possibly be something good? … Muscle tension gives our bodies form, grace, posture, and locomotion.

Certainly there are times when the degree of chronic muscle tension becomes discomforting. And for some, induced relaxation … may be very beneficial. However, there are many with PTSD for whom induced relaxation will precipitate a trauma reaction, increasing hyperarousal and anxiety, risking flashbacks. There are no studies that discuss this phenomenon; it is an area yet to be researched. (some articles mention it)

In such cases, building or maintaining muscle tension is preferable to relaxation. Simple body awareness is a reliable measure of which is best for a particular client. Clients who become calmer with relaxation can benefit from it. Those who become more anxious when relaxing may be better off tensing instead. There may be a generalized positive or negative response to tensing or relaxation throughout the body. But it is also possible to have a positive experience tensing a particular muscle and a negative experience tensing another.

… Muscle tensing has helped many reduce these unpleasant sensations – even to the point of enabling sleep. The kind of tensing being discussed here does not include aerobic exercise. That is contraindicated for some individuals with PTSD and panic attacks, as the elevated heart and respiration rates can be trauma triggers in themselves. Rather, it is slow, focused, muscle-building exercise that is beneficial in these circumstances. For this kind of muscle building to be effective it must be done with body awareness – with attention to body sensations generally and to the muscles being exercised specifically. Also, the exercise must stop at the point of mild tiredness in the muscle, while it is still a pleasant experience.

Tensing Peripheral Muscles – Holding Together

* *Side of Legs:* Stand with feet a little less than shoulder-width apart, knees relaxed (neither locked, nor bent). Press knees out directly to the side so that you can feel tension along the sides of the legs from knew to hip
* *Left Arm:* Sit or stand with arms crossed right over left. The right hand should be covering the left elbow. First, the right hand provides resistance as the left arm lifts directly away from the body. You should feel tension in the forward-directed part of the upper arm from shoulder to elbow. Next, the right hand provides resistance to the back to the elbow as the left arm pushes directly left. You should feel tension in the left-directed part of the upper arm from shoulder to elbow.
* *Right Arm:* Sit or stand with arms crossed eft over right. The left ahand should be covering the right elbow. First, the left hand provides resistance as the right arm lifts directly away from the body. You should feel tension in the forward-directed part of the upper arm from shoulder to elbow. Next, the left hand provides resistance to the back of the elbow as the right arm pushes directly right. You should feel tension in the right-directed part of the upper arm from shoulder to elbow.
* *Thighs:* Sitting in a chair, place both feet flat on the floor. Press weight onto your feet just until you feel tension build in your thighs.

**Therapeutic Distance Boundary Exercises**

Proximity exercise (*familiar one done before*)

The second exercise involves the use of yarn to help visualize one’s boundary. The client in individual therapy or in a group therapy takes a length of yarn and uses it to draw a circle around himself at the radius he perceives is comfort distance to be. It is good to have the client talk about the experience while he is doing it, including how it feels in his body to make his boundary concrete. Then, with the client’s permission, the therapist can roam about the room moving in and out of the client’s boundary (as we actually do with others all the time). The client is asked to track his somatic and emotional responses, expressing what is happening while the therapist walks. He should notice when he feels an unmolested space, and when he feel intruded on. He should also feel free to adjust his boundary at any time. A point worthy of note: The wider the radius of the boundary, the more easily it is invaded and the more frequent and intense the client’s feelings of intrusion. Eventually, the client can be taught to redraw his boundary (actually with the yarn, as well as figuratively).

When the client is ready, an additional intervention can be useful: With the client’s permission the therapist comes to a pause just inside the client’s yarn and does not move. The client will usually feel uncomfortable, sometimes angry. The therapist then helps the client to figure out that if he redraws his boundary in a tighter circle around him, the therapist will no longer be intruding inside of his boundary. Often this gives a client a feel ing of mastery over his personal space that he can take out into his daily life in business, social, and personal contacts, on public transportation, in restaurants, etc.

**Establishing a Sense of Boundary at the Skin Level**

Trauma and PTSD are often the result of events that were in one way or another physical invasive: assault, rape, car accidents, surgery, torture, beatings, etc. Often it is loss of the sense of bodily integrity that accelerates a trauma process out of control. Re-establishing the sense of boundary at the skin level will often reduce hyperarousal and increase the feeling of control over one’s own body. To increase the sense of bodily integrity, I often suggest that a client physically feel his/her periphery/boundary – the skin. This can be done in several ways:

1. Have your client use his own hands to rub firmly (not too light, not too hard) over his entire surface. Make sure the rubbing stays on the surface – skin (clothes over skin) – and does *not* become a gripping or massaging of muscles. If your client doesn’t like touching himself, he can use a wall or door (often a cold wall is great) to rub against a pillow or towel to make contact. Remember, especially, the back and the sides of the arms and legs.
2. Some clients will feel too provoked even toughing their own skin or being observed doing it. In that case it might work to have them sense their skin through sensing the objects they are in contact with. Have the person feel where his buttocks meet the chair, his feet meet the inside of his shoes, the palms of his hands rest on his thights, etc.
3. As the client does one of these, it is sometimes also useful to have him saying to himself, “This is me,” “This is where I stop,” etc.

**Working with the aftermath of the Trauma First**

Every traumatic event is comprised of three distinct stages, any one of which can increase or decrease the ultimate impact of trauma. The three stages are:

1. Circumstances leading up to the traumatic incident
2. The traumatic incident itself and
3. The circumstances following the incident, both short-term and long-term.

The time following a traumatic event is critical. The quality of contact and help the victim receives can greatly influence the outcome. It is for this reason that it is often advisable to resolve the issues following a traumatic incident first, before attempting to address the incident itself. Sometimes what occurs after the incident is more emotionally devastating than the incident itself.