



SOMATIC EXPERIENCING®

ADVANCED YEAR

Module 1

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ADVANCED YEAR

Introduction/Overview

In the Advanced year, the art and science of SE come together to provide a more subtle and nuanced understanding of the application of SE principles and methods, particularly as they apply to the most complex traumatic stress symptoms. Most clients with serious trauma histories don't come into our offices with straightforward, easily understood symptoms. They come in because of physical, emotional, and relationship pain. They don't feel like themselves; they may experience anxiety or depression, coupled with physical symptoms of uncertain origins. Their symptoms are disrupting their lives, but most do not have a single symptom; instead, they come in with a complex of interrelated issues, or a cluster of symptoms.

In the Beginning year of the SE training, the focus was on understanding the physiological basis and impact of trauma, and on learning the fundamental building blocks of the SE approach. In the Intermediate year, fundamental principles and methods were applied in the context of specific categories of traumatic experiences. This provided a more event-specific focus for the interventions used in the SE model. In the Advanced year, we make the transition to a more organismic view of the effects of trauma. Working effectively with clients who have complex and interwoven traumatic symptoms requires a deep understanding of how the whole of their organism has been affected.

The methods presented in the Advanced year of the SE training are those that are needed to work with highly disorganized physiological systems, such as occur in syndromes. They require an understanding of the eccentric responses that arise in the face of heroic efforts at managing extreme levels of disruption in the physiology, or in the face of extreme threats to survival. The irony is that the methods used for working with these most complex of physiologies have a fundamental simplicity in their approach. In the Advanced year, we will learn to hold complexity and simplicity simultaneously in our practice of SE.



STABILIZATION MODEL

Humans are fundamentally rhythmic beings who are self-organizing, self-regulating and self-healing — when conditions are such that these capacities are allowed to function uninterrupted. Under conditions of unresolved traumatic stress, these self-regulating capacities become disrupted, which in turn is reflected as diminished inherent organismic rhythmic capacity (pendulation), reduced resiliency, and increased disorganization of the physiology.

As we learned in the Intermediate year, the Global High Intensity Activation category is an example of highly disorganized physiology that attempts to stabilize via complex under- and over-coupling. This apparent stability is, of course, tenuous and quite easily disrupted. In order to work effectively with highly disorganized systems, it is important to first establish a greater level of actual stability. There are two essential components for establishing deep stability in an otherwise disorganized system: coherence and containment.

Coherence

Coherence: **1.** *The quality of being logically integrated, consistent and intelligible; congruity.* **2.** *Physics: that property of a set of waves or sources of waves in which the oscillations maintain a fixed relationship to each other.*

The overall theme of the Advanced year of the SE training is coherence. Coherence is a measure of wholeness. When connected to the deep self, we feel 'whole'. Organization within body systems and cooperative, organized function between various physiological systems contributes to our sense of well-being, or wholeness. Tracking objectively is difficult, since saying 'whole' to different people can mean different things and be experienced in different ways. Coherence reflects a homeostatic state in which the organism is self-regulating in an optimal way.



"Trauma is fundamentally a disturbance in the ability to be in the here and now."

— van der Kolk

"Coherence can be defined as: Connected, Open, Harmonious, Engaged, Receptive, Emerging, Noetic, Compassionate, Empathic."

The movement toward well-being is a movement toward Integration. Coherence entails a flexible state of harmony that embraces the many aspects of neural functioning and interpersonal connections... brain stem, limbic/right and left hemisphere processes. As Integration is achieved across the numerous dimensions of living, a sense of the unity of being is revealed."

— Daniel J. Siegel,
(in press) Mindsight

As coherence within any one body system increases, that system is more stable. As coherence between body systems increases, the overall organism as a whole becomes more stable. Supporting the client to move toward coherence will help establish the necessary stability, particularly in parasympathetic function, to renegotiate the deepest traumatic stress states.

How Will We Notice Coherence?

Coherence is what allows the organism to function effectively as a whole. Coherence can be measured between physiologic subsystems. The operative variable is respiration. In a healthy system, a deep inhale increases heart rate, followed by a decreased heart rate upon exhalation. This is called Heart Rate Variability (HRV). In a coherent system, with each breath, there is modulation of the heart rate, as well as of vasomotor and muscle tone; the exception to this natural state is where there's been severe trauma.

- In a peaceful state, there is a unison of heart rate, vascular rhythm, respiratory rate, and micro-muscular activity (electromyographic readings).
- When coherence is present, one feels whole and knows when one is "in the zone".
- In a state of coherence, the physiology does what it's supposed to do; it works as it should. It does the right thing and functions the right way. It is self-organizing and self-regulating.
- In the absence of over- or under-coupling, the breathing rhythm will be carried throughout the body, giving a subtle sensation of each area of the body "breathing" in coordinated rhythm with the respiratory process.
- We track coherence through the breath, heart rate, muscle activity, shifts in skin color (i.e., pallor to flush), and via touch.



HRV

In health, the in-breath causes heart rate to increase slightly (accelerate) and the out-breath causes the heart rate to decrease slightly (decelerate). Heart rate variability (HRV) is the difference between these two rates; looking at the overall pattern can tell a lot. In general, healthy people less than 50 years old have HRV of 20 beats difference. Healthy people older than 50 have HRV of 11 beats difference. There is a high correlation with death if there is little HRV (low HRV means there is underlying sympathetic activation).

— Levine

Resonant Frequency

- Each heartbeat is a strong electrical signal that influences the body; it is an organizing principle.
- 0.1 Hertz +/- .01 is the heart's resonant frequency at its most stable and strongest; this is a measure of integration and coherence.
- When the heart is at this frequency, the brain processes information more effectively, and the immune system also functions better.
- A person in coherence can affect others within 5-8 feet of themselves; an agitated person nearby may begin to join, resonate, and calm down with someone calmer nearby.
- Being in a resonant state of coherence tends to protect us from the disorganized states of others around us. — Levine

Supporting and Encouraging Coherence

Trauma can catapult an organism into incoherence and dissociation. Chronic arousal and shutdown creates patterns of incoherence (patterns of interwoven under- and over-coupling). Supporting the restoration of coherence can begin to unravel these interwoven coping strategies. Above all, resting in our own resonant coherence will act as an invitation to the client to also move toward greater coherence. In effect, the discussion of coherence can act as a review of coupling dynamics. Using the muscle system as an example:

- When the muscles are hypertonic, braced or constricted, they resist and restrict the natural expansive wave that moves through the musculo-skeletal system on the inhalation. This can be seen as a form of over-coupling.
- When the muscles are hypotonic, slack, or lacking in tone they do not have enough appropriate tension to transmit the natural wave of the breath. This can be seen as a form of under-coupling.

In both cases, the practitioner would observe limited expansion and contraction (pendulation) in response to the respiratory rhythm. However, the cause of that limitation of breath is different: in one case it's due to constriction (over-coupling), in the other, it's due to lack of tone (under-coupling).

As in any work with coupling dynamics, the practitioner supports each movement toward healthy coupling. Movement out of constriction and into differentiation is supported, as is movement toward reconnection and restoration of appropriate tone. We thus support the restoration of the natural rhythm of pendulation and the return to coherence.

The appropriate use of touch is particularly helpful in working to restore coherence. The easiest way to notice coherence is to learn to recognize it through touch. It is extremely difficult to see coherence before you've touched it. As you practice with touch, you can learn to feel the most subtle micro-tensing of muscles, or the most subtle return of the breath rhythm to tissues. Touch also inherently tends to invite coherence.

Moving to Higher Orders of Coherence

A very important phenomenon to be aware of as you work more with coherence is that there will be an increase in apparent disorganization as the system moves toward a higher order of organization. In chaos theory, what appear to be chaotic or random processes in fact have intrinsic order when viewed from this broader perspective. Likewise, the restoration of deep coherence sometimes involves periods of apparent disorder as the organism moves out of its disrupted, locked state into a more mobile and

flexible pattern. The movement from disorganization toward organization and coherence happens in phases, with periods of apparent disorganization alternating with each level of deeper coherence. The challenge, of course, is to manage the process effectively enough that the movement is in fact toward greater coherence, and not into further fragmentation and disorganization.

Containment

"Containment is an increased capacity to expand in response to the inner pressure of activation." Levine

As a client's ability to contain and integrate high levels of activation increases, your work can progress more quickly. When there is little capacity to contain high energy states, your work must progress more slowly. Activation is not inherently threatening; rather, it is the client's response to it that poses the difficulties.

Much of the work done with highly disrupted physiologies is to increase the capacity to contain high levels of activation without provoking the extreme coping mechanisms that "lock" the organism into its artificial (traumatic) stability. Without appropriate containment, energy mobilized within highly disorganized systems will provoke the very processes that caused the system to become overwhelmed in the first place: unmanageable activation or shutdown (and sometimes, constant oscillation between the two). Once the client can tolerate at least gentle mobilization of some of the bound survival energy in their system, they can allow access to that energy without overwhelm.



"Whenever you have an increase of energy and a simultaneous increase in coherence, you know you're on the right track."

— Levine

The tools used for building both coherence and containment are the most familiar within the SE repertoire: titration and pendulation.

Titration, Pendulation

The skills needed on the part of the practitioner to work with deeply dysregulated systems, and for restoration of coherence, are:

- The capacity to work with the smallest possible titrations
- The ability to observe the most subtle indicators of pendulation.

The practice of these two essential SE tools in the Advanced year is taken to an exponentially more subtle level than has been the case in the Beginning and Intermediate years.

A special thank you to Louise Peyrot, who transcribed original class lectures of Dr. Peter Levine, which were used as the basis for both Advanced modules. Steve Hoskinson, Kathy Kain and Raja Selvam also contributed to the Advanced material.



ADVANCED YEAR

Module 1

Polyvagal Theory

In order to work effectively with syndromes and deep shock states, it is helpful to understand more about the dynamics of the sympathetic and parasympathetic nervous systems. The polyvagal theory is a useful model that illuminates some of the eccentric physiological responses that can occur in traumatic stress physiology, particularly under conditions of chronic management of traumatic stress states.

According to Stephen Porges' Polyvagal Theory, the autonomic nervous system is actually not comprised of two reciprocal systems (parasympathetic and sympathetic), but rather of three sequential systems that follow brain evolution:

Dorsal Vagal System (DV);

part of the Parasympathetic Nervous System

The most primitive of the ANS branches, this ancient system is an oxygenconservation system, and causes the shutdown (freeze) seen in severe trauma. This dorsal vagal state is typically understood as a state of shock.

- Dorsomotor nucleus, nucleus tractus solitarius
- Think "live in the sea"
- Helps the body conserve oxygen by shutting down the need for oxygen Lower use of energy ("slow down and shutdown")
- Decreased heart rate
- Decreased respiration
- Minimal movement and metabolism
- "Immobility" response
- "Diving reflex"
- Unmyelinated

Sympathetic Nervous System (SNS)

"The sympathetic nervous system is primarily a system of mobilization. It prepares the body for emergency by increasing cardiac output, stimulating sweat glands to protect and lubricate the skin, and by inhibiting the metabolically costly gastrointestinal tract." — Porges, "Emotion: An Evolutionary By-Product of the Neural Regulation of the ANS."

- Sympathetic circuitry includes the adrenal glands (produce adrenaline and cortisol). The endocrine system is very active in helping us stay safe, protect our young, and/or flee.

- Fighting and fleeing takes a great deal of energy. Because the SNS uses a lot of metabolic energy, it is considered an energy-spending system, although it has a conservation element via its inhibition of non-essential metabolic processes.
- When aroused, this system takes time to return to a resting state.
- Unmyelinated
- Language of survival through action

Ventral Vagal System (VV); part of Parasympathetic Nervous System

Found only in mammals, this newer system supports social engagement.

- Nucleus ambiguus, neocortex, prefrontal cortex
- Think "social engagement" (facial linking) & "make friends to solve problems".
- Orientation involves the VV.
- This is a myelinated system (myelination speeds up transmission of electrical impulses). Myelination begins at birth and continues throughout childhood. The brain matures through the mid-teens and neural fibers continue to become myelinated. Myelination facilitates growth, learning, social connection, and the sense of touch.
- Myelination of VV nerve axons contributes to "smart" ability of VV.
- Myelination allows high conduction velocity and precision.
- Adapted to high oxygen needs; subtly tunes heart rate.
- VV conserves energy until degree of threat determined.
- During insignificant threat, VV inhibits sympathetic from taking over.



"The (Polyvagal) Theory emphasizes the phylogenetic dependence of the structure and function of the vagus, the primary nerve of the parasympathetic nervous system. Three phylogenetic stages of neural development are described.

The first stage is characterized by a primitive unmyelinated vegetative vagal system that fosters digestion and responds to novelty or threat by reducing cardiac output to protect metabolic resources. Behaviorally, this first stage is associated with immobilization behaviors. The second stage is characterized by a spinal sympathetic nervous system that is capable of increasing metabolic output and inhibiting the primitive behaviors necessary for "fight or flight." The third stage is unique to mammals and is characterized by a myelinated vagal system that can rapidly regulate cardiac output to foster engagement and disengagement with the environment...In addition, the mammalian vagal system has an inhibitory effect on sympathetic pathways to the heart, and thus, promotes calm behavior and pro-social behavior."

— Porges, "Emotion: An Evolutionary By-Product of the Neural Regulation of the Autonomic Nervous System", from www.wam.umd.edu

NOTE: Babies are born with fully functioning dorsal vagal systems. The sympathetic system develops and begins to function only after birth. The mother acts as the ventral vagal (soothing) system until the baby's system is myelinated and can begin to regulate itself.

Porges' theory proposes a hierarchical response model, in which the more sophisticated strategies of survival that use social engagement are first attempted. If social engagement doesn't work, then the more primitive sympathetic arousal system (fight or flight) is engaged. If sympathetic arousal doesn't work, then we see the immobility response of the primitive dorsal vagal system as the end-stage survival mechanism. However, even this sequential model has its own complexity: *"The three levels do not function in an all-or-none fashion; rather they exhibit gradations of control determined by both visceral feedback and higher brain structures."* – Porges, as above.

Polyvagal Theory: Phylogenetic Stages of Neural Control (Porges)

Stage	ANS Component	Behavioral Function	Lower Motor Neurons
III	Myelinated vagus, VVC – ventral vagal complex	Social communication, self-soothing & calming, inhibit sympathetic-adrenal influences	Nucleus ambiguus
II	Sympathetic-adrenal system, SNS – sympathetic nervous system	Mobilization or active avoidance	Spinal cord
I	Unmyelinated vagus, DVC – dorsal vagal complex	Immobilization, death feigning, passive avoidance	Dorsal motor nucleus of the vagus

Both branches of the parasympathetic can lower high sympathetic arousal, but each functions differently. The VVC can inhibit heart rate, as can the DVC; when either inhibition is taken away, heart rate increases.

Polyvagal Theory: Emergent “Emotion” Subsystems			
	VVC	SNS	DVC
heart rate	+ / –	+	–
bronchi	+ / –	+	– *
gastrointestinal		–	+
vasoconstriction		+	
sweat		+	
adrenal medulla		+	
tears	+ / –		
vocalization	+ / –		
facial muscles	+ / –		
eyelids	+ / –		
middle ear muscles	+ / –		

*It's normal to shutdown the bronchi if underwater. It's not normal to shut them down when anxious.

Polyvagal Theory and SE

Polyvagal theory helps inform our observations of the nervous system shifts that we see in SE sessions. The involuntary autonomic nervous system (ANS) is responsible for homeostasis. When functioning well, the sympathetic and parasympathetic (dorsal and ventral vagal) systems do their job as designed – to meet the demands of the internal and external environment, and keep the body systems functioning as needed, in both stressful and non-stressful situations.

- If we're socially interacting in a relaxed way, the ventral vagal (VV) is engaged, as are moderate levels of the sympathetic (SNS) and dorsal vagal (DV); i.e., we have enough energy to maintain the dialogue, and we feel well enough inside to be comfortable doing so.
- If we're feeling good inside ourselves without anyone around, the dorsal vagal (DV) is functioning well with moderate levels of SNS and VV in the background; i.e., we are awake and doing something, but nothing taxing or social.
- If we're “resting and digesting” after a hard day's work, the DV should be busy, and the SNS should be taking a break; the VV may have variable engagement (reading vs. catnap).

- If we're running for our lives, the SNS should be hard at work; the VV may help orient where to run to, but is not socially engaged, and the DV pauses until the threat is over.
- If we're drowning, the DV kicks in (after SNS struggle) to close down the airways to prevent water from entering, and shuts down the physiology to minimize oxygen usage.

Ventral Vagal

- From the nucleus ambiguus, the myelinated VV neurons innervate the heart, lung, ear, larynx, pharynx and face. Hearing (ears) and vocalization (larynx and pharynx) are important components of social engagement, along with the facial muscles.
- The ventral vagal system has motor neurons that move the muscles, and sensory (afferent) neurons that send information back to the brain. The afferent information can then influence motor function.
- The human ear intensifies around the human voice; it tunes to specific frequencies so it can hear best. Stephen Porges uses certain frequencies to exercise the acoustic muscles; this afferent stimulation has helped some "unreachable" [autistic] children become "reachable".
- The VV innervation to the heart (vagal tone) keeps the heart rate within a healthy dynamic range. When fight or flight is required, the VV modulation is removed, allowing an increase in heart rate. In some cases, "engaging" the ventral vagal through social engagement can calm down sympathetic arousal, and reduce charge.

Dorsal Vagal

The DV is many-tiered and has a whole spectrum of functions. When overloaded its default settings are shutdown, freeze/immobility, and conservation/withdrawal. However, normal DV functioning is not the same as freeze, and high levels of DV activity do not always equate with shutdown. From an evolutionary biological perspective, how a particular system is used at one stage of evolution does not determine what will next evolve for that system. When a very primitive system is used in a compelling way, and is an integral part of the organism at an early stage of evolution, that same system will likely persist, but be used in a very different way over time. While the original function of the DV worked well for fish and reptiles and was retained in mammals and primates, it did evolve from oxygen conservation to other functions (i.e., evolution used it in a different way). In mammals, the DV system still includes shutdown, conservation/withdrawal, and immobility/freezing as one of its functions, but it's also responsible for our wonderful good feelings. At low levels, it modulates the ongoing activity of visceral function, which is experienced as pleasure and well-being.

The functions of the DV are many:

- To support ambient digestion
- To enhance deep relaxation - In this state, the DV system is probably more involved than is the VV.
- To trigger surges of vomiting and diarrhea in order to expel poisons and release toxins.
- To shut down systems to conserve energy. Shutdown is designed to be time-limited.

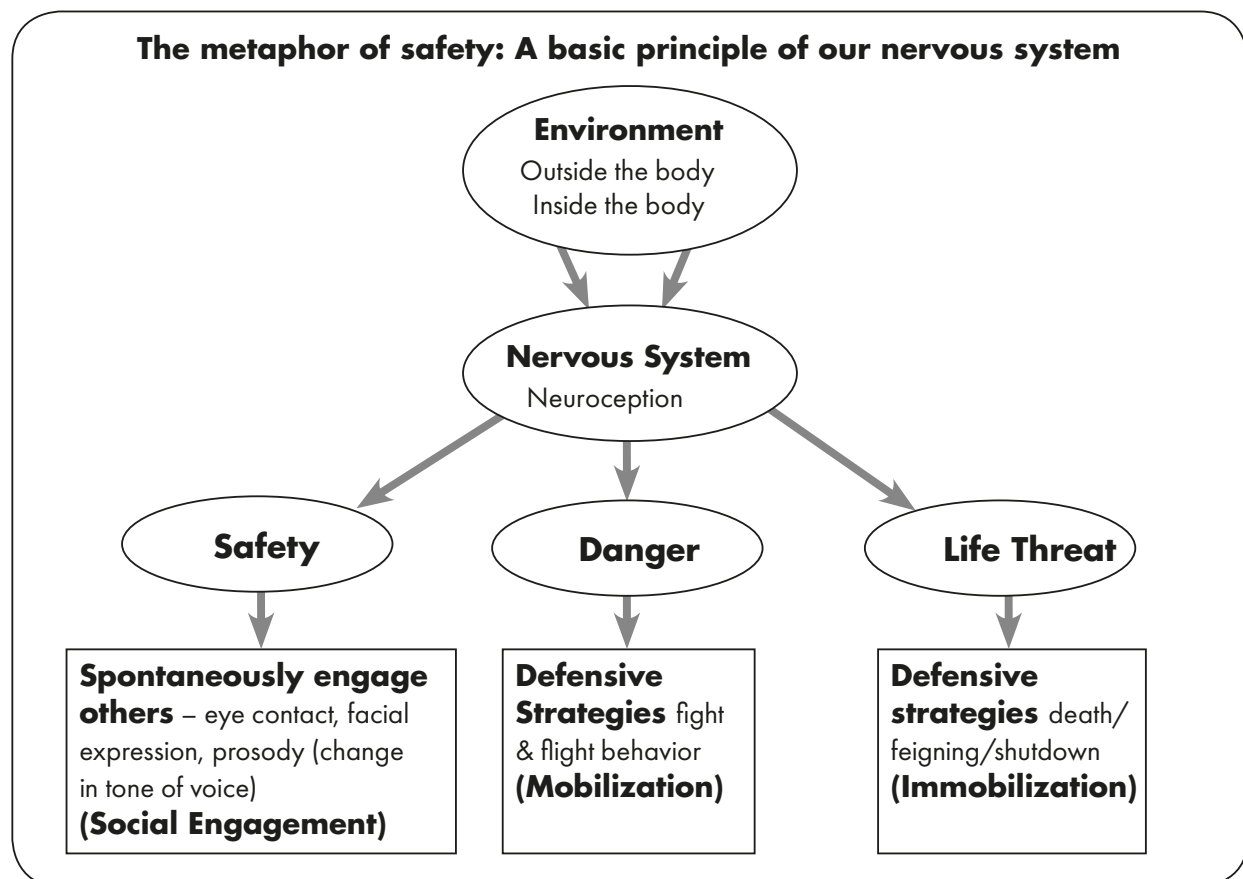
Chronic shutdown occurs when the system is stuck in conservation/withdrawal. This DV shutdown is fear-potentiated; it's a product of immobility coupled with fear.

Neeuroception

Because the neural evaluation of risk does not require conscious awareness, the term neuroception is introduced to emphasize the neural circuits that function as a safety-or-threat detection system that distinguishes whether situations are safe, dangerous, or life-threatening.

Neuroception by Stephen Porges

Neuroception describes the process of how we glean from the nervous system whether things (people, situations) are safe, dangerous, or life- threatening, and whether something is approachable or needs to be avoided.



Stage	ANS Component	Behavioral Function	Lower Motor Neurons
III Ventral Vagal (Social Engagement)	Myelinated vagus, VVC – ventral vagal complex	Social communication, self-soothing & calming, inhibit sympathetic-adrenal influences	Nucleus ambiguus
II Sympathetic Nervous System (Mobilization)	Sympathetic-adrenal system, SNS – sympathetic nervous system	Mobilization or active avoidance	Spinal cord
I Dorsal Vagal (Immobilization)	Unmyelinated vagus, DVC – dorsal vagal complex	Immobilization, death feigning, passive avoidance	Dorsal motor nucleus of the vagus

Understanding the polyvagal theory and neuroreception helps us understand the physiology of our response to threats to our survival. Normally, when the autonomic nervous system (ANS) readies us for fight or flight, there is a positive correlation between muscle tension and high levels of autonomic activity; skeletal muscle and autonomic support go together. In the freeze response, there is intrinsic dissociation. The muscles are either frozen (can't move) or collapsed (lacking in tone), yet there is still strong autonomic activity (both sympathetic and parasympathetic). In terms of mobilization, this doesn't make sense. However, neurotransmitters (like adrenaline) do not make the muscles move. Muscle movement is initiated by the motor cortex. In SE, we are most concerned about completing movement impulses to fight or flee.. If a movement impulse is blocked, traumatic symptoms will develop. If the impulse completes, traumatic symptoms will not develop. If the impulse does not complete, but the tremendous energy mounted is shaken out and discharged, no traumatic symptoms will develop.

It's difficult to switch **back** from freeze to the ANS, and organize for mobilization. This is what we help clients do in sessions; we look for the ANS responses to re-initiate, and we help the ANS to respond **actively** (fight, flight, or social engagement). Active social engagement takes many forms (laughing, playful, joking, etc.). Energy to play, have fun, make up stories, dance, etc. becomes available after it's unlocked and allowed to flow. Play is channeling of the active autonomic responses, but at a moderate level that is generally experienced as pleasurable, rather than as danger or threat. Ultimately, neuroception of safety (social engagement) is not only parasympathetic; it's a balance of sympathetic and parasympathetic functions in an active, playful manner.



SYNDROMES

Overview

Overview

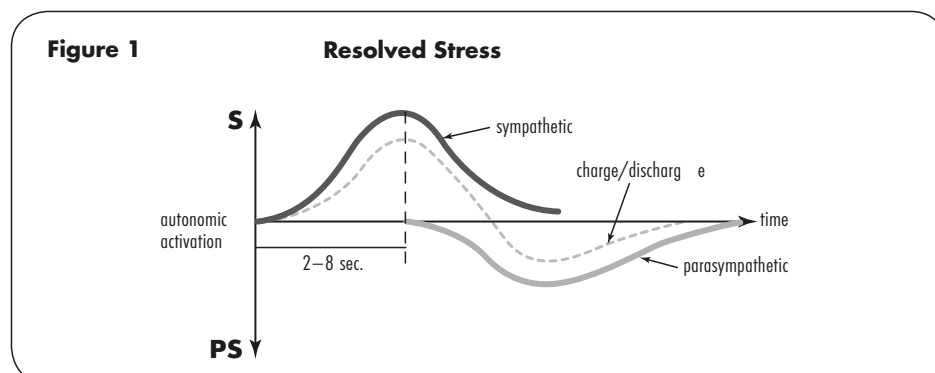
By design, the ANS switches systems on, off, or modulates its degree of function, according to internal and environmental demands. After strong demands (for short-term intense alertness and skeletal muscle and energy expenditure) have subsided, the system is designed to settle back down and reset itself, or else shutdown completes and more active engagement returns. When neurotransmitters are secreted, the body secretes the chemicals to break them down to maintain internal homeostasis. This prevents neurotransmitters and their effects from lasting beyond the time needed.

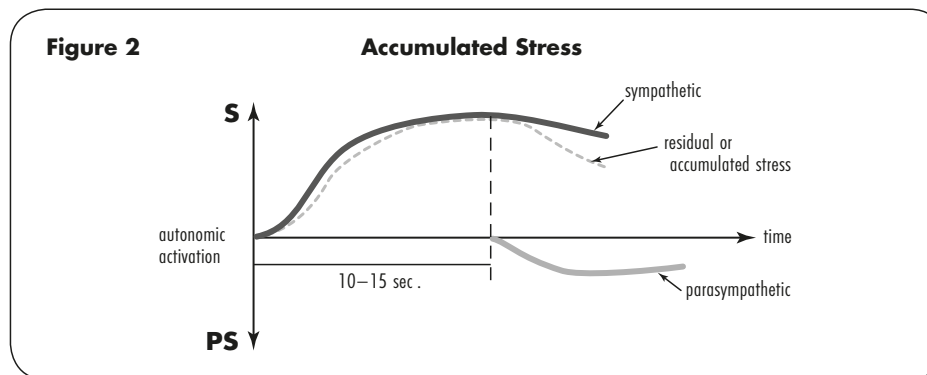
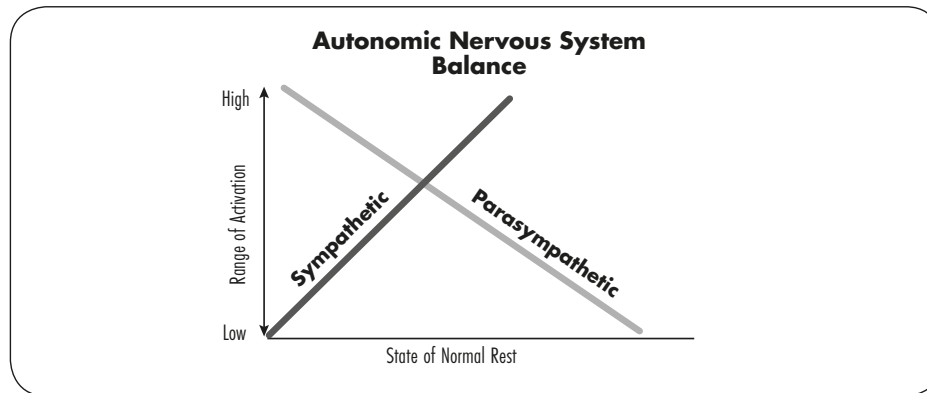
The ANS can be understood to have “thresholds” for when the ventral and dorsal vagal and sympathetic systems turn on or off. Things go awry if these internal thresholds are altered; systems turn on when they shouldn't, or don't turn on when they should. When things go awry, some systems do their job at the wrong time, failing to work together with other systems with which they are designed to function; instead, they work at “cross purposes”.

Syndromes show strange autonomic patterns that indicate disorder in the ANS; somehow, full resetting doesn't occur, and in some cases systems are working oppositionally. Some aspect of ANS-mediated vascular, hormonal, or muscular disorder is seen in most syndromes. A syndrome is a group or complex of symptoms that collectively indicate or characterizes a disease, psychological disorder, or other abnormal condition. Examples of common syndromes with possible sympathetic/parasympathetic-mediated dynamics include: migraines, fibromyalgia, autoimmune disorders, pain syndromes, irritable bowel, spastic colon, sympathetically mediated pain syndrome (reflex sympathetic dystrophy).

Resilient, Reciprocal Relationship Between the Sympathetic & Parasympathetic Systems

Ernest Gellhorn discovered that the reciprocal relationship between the sympathetic and parasympathetic systems occurs only in relatively low to moderate nervous system activity. If the sympathetic nervous system (SNS) is stimulated briefly (2-8 seconds), it returns to a resting state fairly quickly. In such short periods of stimulation, the parasympathetic activates to rebalance the sympathetic (see Figure 1, **Resolved Stress**, below). However, stimulation of the SNS for 10-15 seconds produces accumulated sympathetic stress; the sympathetic system remains activated. (see Figure 2, **Accumulated Stress**, p. A1.18).

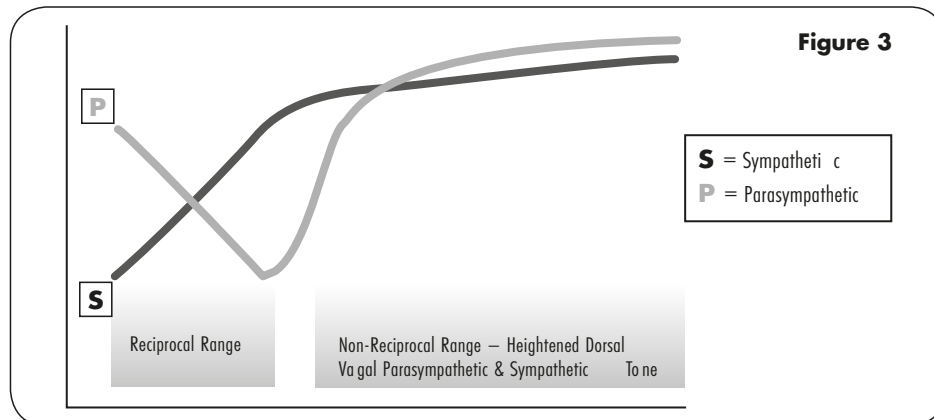




Non-reciprocal Relationship Between the Sympathetic & Parasympathetic

If the stimulation of the SNS lasts longer than 15 seconds, the parasympathetic activity is initially lower; if longer still, there is a reversal effect. With increasing arousal of the SNS, a point is reached where the reciprocal relationship between the parasympathetic & sympathetic is lost. At this point, the parasympathetic system rises as well (see **Heightened DV & Sympathetic Tone**, Figure 3, p. A1.19). When a system is functioning within this range, we see unstable behaviors and unstable physiologic states. The system is in chaos and responds abnormally. The system is dysregulated and functioning within a narrow range; therefore, it is less resilient.

Once the client's physiology is functioning in this non-reciprocal range on a chronic basis, you can no longer trust their parasympathetic system or resources. Instead, the client needs to gain access to their deeper self, their deeper coherence and capacity for containment, which will help bring their system back to equilibrium. There are specific techniques used within the SE model that are particularly effective to work with such highly disorganized systems (see following sections). Once the client's physiology has returned to a more normal reciprocal range and they have full access to the stability provided by resilient parasympathetic function, the usual SE methods again become effective, and your work with the client can then proceed along the more typical SE path.



Symptoms & Syndromes

Traumatic stress symptoms that present in syndromal patterns, can be seen to arise from accumulated traumatic stress that binds high levels of energy and disorganization within a highly dysregulated physiology. When the sympathetic and parasympathetic systems operate in relative reciprocity, they fluctuate on and off. When reciprocity breaks down, there will be large shifts where one system is predominant, and then abruptly (in some cases catastrophically), the other becomes predominant. For example, a person experiences constipation (sympathetic), but following a minor triggering experience, their body jumps in the other physiological direction and has a surge of diarrhea (parasympathetic). Such seemingly minor triggers can be external (a little perturbation, excess light, noise) or internal (the person is a little irritated, or relaxes a bit). This basic type of instability underlies the core problem in syndromes; the key to syndromes is dysregulation in the ANS.

Somatic Syndromal Symptoms

- Intense trauma (i.e., hard to contain & intolerable) is bound in symptoms. There is a complex binding of energy.
- Without discharge, symptoms bind incomplete responses and unresolved activation.
- Activation bound in syndromes is orders of magnitude higher than that bound in one symptom; this is why you see dissociation of undercoupled elements, which organize in a particular energy pattern. There is a kindled, associative nature to the symptoms.
- Symptoms have repetitive patterns that cluster; as patterns solidify, they become syndromes (the body is trying to stabilize in some way).
- Syndromes are defined by a consistent pattern/collection of symptoms.
- Syndromes have mercurial properties (changeable, come back together). Symptoms tend to mutate; there is deep concern if there is no variation.

- Some syndromes are commonly found grouped together (fibromyalgia, chronic fatigue, irritable bowel, leaky gut syndrome).
- High level of sympathetic (cortisol, adrenaline, noradrenaline) and parasympathetic activity simultaneously.
- Loss of continuity of felt sense. Loss of continuity of behavior (often fragmented, less coherency).
- Pain floats around the body.
- Stimulated by excitation (this is why a resource may trigger).
- Syndromes regroup when a symptom is medicated; the body finds a way around the medication effect since the underlying Global High Intensity Activation (GHIA) and autonomic response haven't been diminished.
- Aim is to work autonomic dysregulation toward regulation.
- Functional syndromes are trauma- and stress-related (compared to a disease like multiple sclerosis, where observable pathological change exists).
- Syndromes have a basic dysregulatory/incoherent nature.
- Most have autonomic patterns of distorted sympathetic and parasympathetic activity: fight, flight, freeze and loss of reciprocal sympathetic/parasympathetic function.
- Charge and discharge create the see-saw balance between the sympathetic and parasympathetic systems.

Working With Syndromes

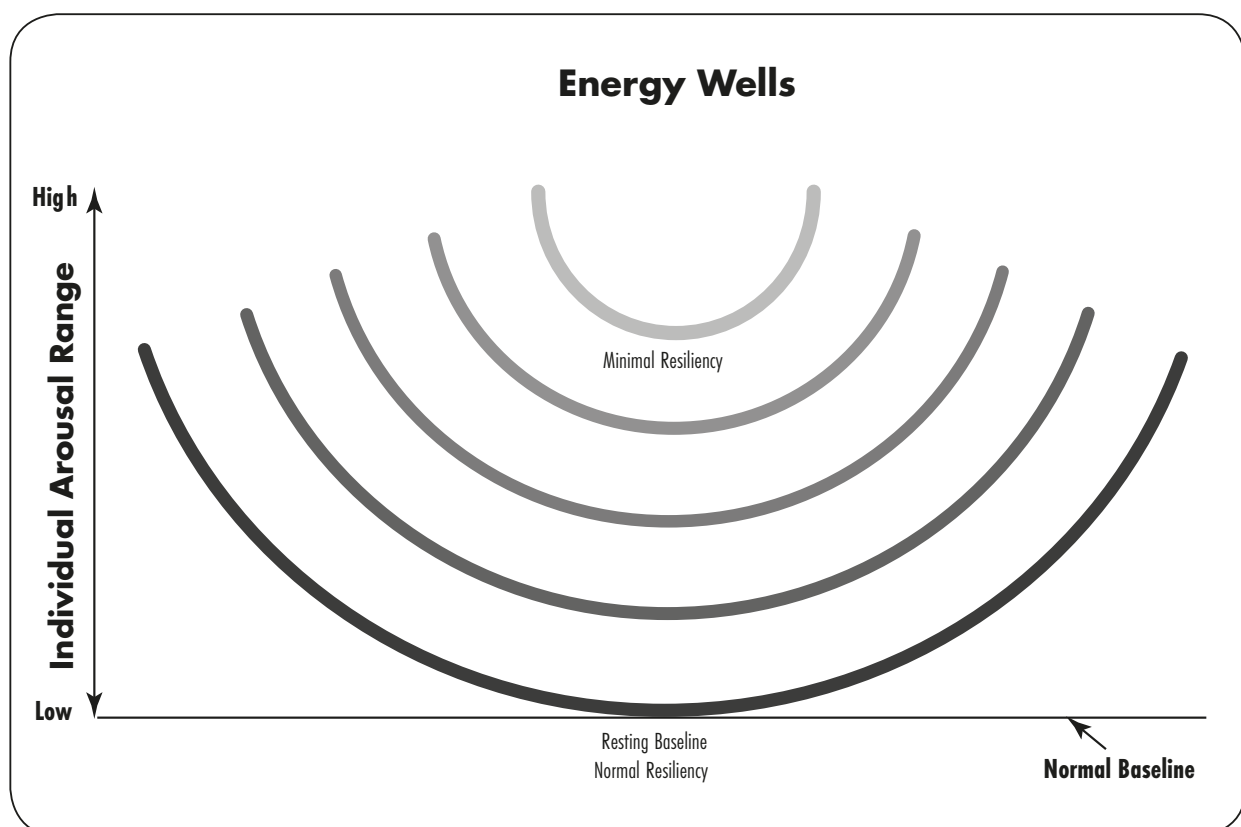
As stated previously, the key to success with syndromes is to work with the dysregulation in the ANS. Since syndromal patterns typically indicate high levels of disorganization, it's critical to work in the smallest possible increments (titrations), so as to begin to mobilize the bound energy in a way that is manageable, and maintains as much stability in the system as possible. There needs to be a strong focus on containment and stability in order to prevent uncontrolled mobilization of the high-energy states of GHIA, which can throw the client into further disorganization and a massive increase in symptoms. Typically, the organism has made heroic efforts to create at least some form of stability. This can be symbolized in the Energy Wells diagram, next page.

This Energy Well diagram shows a large expanded well at the bottom, and increasingly smaller wells progressing upward. The small wells illustrate a limited capacity to explore and be in the world, and a limited capacity for containment (i.e., minimal resiliency). The aim of trauma therapy, over time, is to help a person's restricted system find progressively larger energy wells in which to live. It is important to understand that a dysregulated system has adapted to a tiny range of function, and stays there while defending against further activation. Life-threatening events, followed by further life stress, can leave a person in a very restricted, inhibited state of high sympathetic and parasympathetic charge, which "locks" the system. The effect is much like revving an engine while simultaneously stomping on the brake. Returning to live in a larger energy well means that the underlying freeze has to be discharged,

and incomplete impulses for fight or flight responses must be completed. This process returns the body to a state where normal regulatory processes can engage to heal. Helping a person renegotiate these patterns returns their system to a much larger energy well, and allows them to literally and figuratively climb mountains (sympathetic) and rest by a stream (parasympathetic) without derailing physiologically.

The challenge is to stimulate the system so it mobilizes slightly, beginning a gentle pendulation within a single energy well. Once there is relative stability with this initial movement of the bound energy, movement into the next larger energy well can take place; and so on through each subsequent energy well. With each subsequent, larger energy well, there is more energy and, ideally, greater capacity to contain that energy. In highly dysregulated systems, you might do zero titrations during the first session(s). In other words, you would not facilitate movement toward a larger energy well – just small mobilizations within the existing constrictions.

In this form of work, it is critical that stimulations be kept to a minimum so that the client's artificially-stabilized system doesn't become uncontained and move in an uncontrolled way toward larger and larger energy wells (higher energy states). Such sudden expansion can release too much bound energy at once, thus further destabilizing the system. The most typical after-effect of this kind of rapid expansion will be that the client's system moves to an even tighter, smaller energy well (more constriction) in an increased attempt to stabilize the wild physiological swings that arise from the now-unbound energy moving without appropriate containment.



Titrated Stimulation

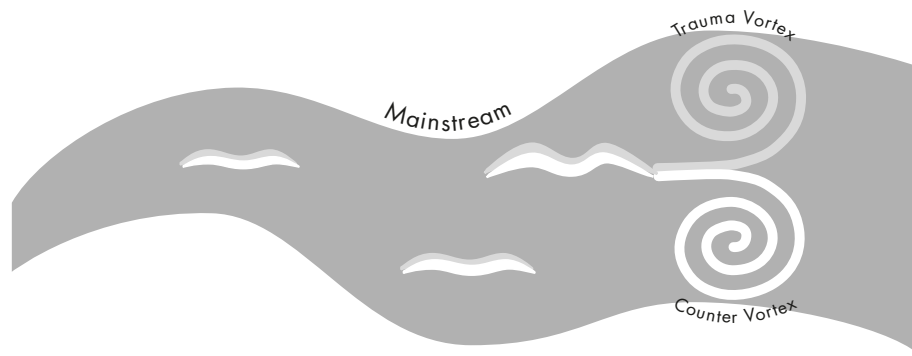
There are a number of ways to gently stimulate such dysregulated systems in order to invite movement within a single energy well, or from one energy well to another. We can look to the polyvagal theory for some possible ways this might take place. We can stimulate the physiology through any of the ANS branches: dorsal vagal, ventral vagal, or sympathetic. Keep in mind that each stimulation and titration must be small, precise, and of short duration. Otherwise, the client's limited capacity to contain the high energy states can be overwhelmed.

- **Start with the positive.** Until a client has at least some parasympathetic resiliency, he or she will not be able to tolerate much stimulation of any kind. The main strategy to establish this initial resiliency as you begin to work with high levels of dysregulation is to wait until the client experiences something that is positive, and focus on that sensation as the starting point. In fact, your first few cycles of work with the client (within a session, or during a number of sessions), might consist of focusing primarily on any positive sensations they experience.
- **The Vooo sound.** Have the client make a low, vibratory sound (think foghorn), centered in the abdomen. This gentle vibration slightly mobilizes the digestive tract, providing feedback through the vagus system (specifically, the dorsal vagus) to begin to "unlock" the parasympathetic brake, which will allow a small amount of the sympathetic activation to mobilize.
- **Social Engagement.** Remember that social engagement is mediated by the ventral vagal aspect of the parasympathetic system. By engaging the client in pleasurable interactions, you keep the ventral vagal system active (through eye contact, voice modulation, relaxed body posture), and therefore enhance its gentle braking of the SNS. At the same time, the activity of socially engaging (laughing, changing posture, sharing past experiences) brings low-level arousal into the system (sympathetic).
- **Focused tracking.** Have the client track sensations in a very focused way, so they do not become overwhelmed by the wash of sensations that arise in high energy states. By noticing the challenging sensations that they deal with on a regular basis, the client's sympathetic activity will increase. This again mobilizes the system – but it must be done in the tiniest titrations so as to prevent overwhelm.

Returning to the stabilization model presented in the introduction, there must be adequate parasympathetic resilience and function (coherence and containment) to maintain stability in these disorganized systems as you begin to mobilize the high energy states. In SE language, the counter vortex must match and counterbalance the energy bound in the trauma vortex. At the same time, don't stay too long in either the trauma vortex or the counter vortex; go to the mainstream instead. Remaining in either vortex will release too much energy, and the body won't be able to reset and stabilize at this new level.

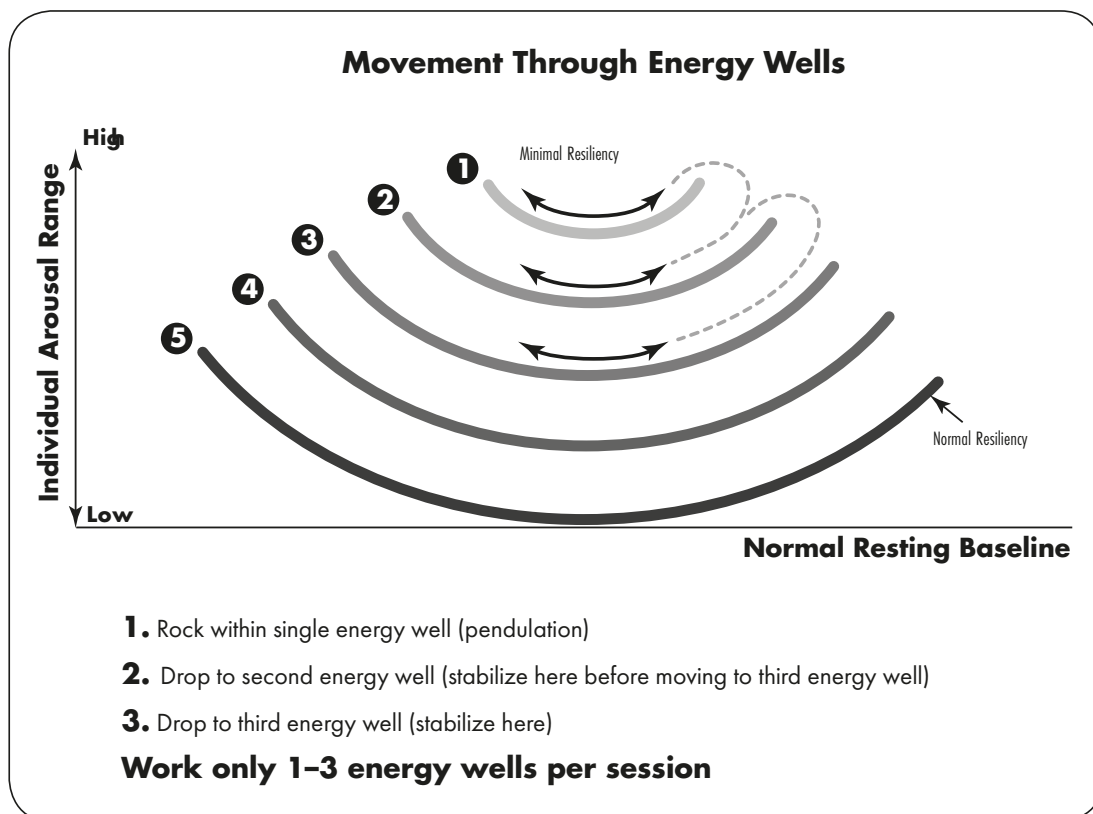
In working with syndromes, it's typical to spend the majority of the session taking time for integration and orientation. The physiology is deeply reorganizing itself during these times of staying in the mainstream, and it is critical to allow sufficient time for this deeper coherence to develop. A metaphor

for this is to think of the stream of life expanding so that the trauma vortex and counter vortex are contained within the continuity of the mainstream of the self.



Movement Through Energy Wells

The first stage is to invite or initiate movement within a given energy well. When there has been enough “rocking” to create discharge and drop the client one level lower, help them stay in this new well; broaden and stabilize their experience there. Greater differentiation occurs as the client moves into and explores a second energy well; different aspects of SIBAM appear, integrate, and move toward coherence (as one feels new experiences).



- Work only 1-3 energy wells per session. As stated previously, with some clients you may not progress outside the first energy well. Even with clients who have some resiliency, moving to a third energy well would be a challenge for the process of integration.
- Titrate precisely; move from collapse to anxiety with just enough activation to return to self-regulation and balance. This process allows movement from one energy well level down, and the life force begins to come back. DO NOT allow the client to dive deep into a lower energy well.
- Sudden activation can shoot the client back up to the smallest well; triggers can be overwhelming and lead to further constriction.
- Almost no discharge takes place in the higher energy wells. More discharge occurs in the lower energy wells. As a therapist, help clients become comfortable with discharge.
- When the client is in an agitated state, have them keep their eyes open (this utilizes neocortical executive function).
- When a person whose system is dysregulated is taught a relaxation technique, the parasympathetic system is activated. It can then reactivate the underlying sympathetic, and that system continues to struggle to find its way back down from the non-reciprocal range. In this context, active attempts at having the client "relax" are counterproductive.
- Have clients pause and take time to reflect on what's happening; this enhances reconnection within the deeper structures of the prefrontal cortex. Suggest they "Take time to prepare before the next step". Eventually, the client will be able to pace the session by letting you know when they are ready for the next cycle, or movement to the next energy well.
- Remember, pendulation is an inherent quality of the life force; there will be natural movement between the contraction of the sympathetic and the expansion of the parasympathetic systems. In a resilient nervous system, when trauma energy is released, it oscillates, pendulates, and returns to equilibrium.

Conscious intention can't be used to ultimately change the function of the DV system or the shutdown, freeze/immobility state, but it can be dramatically important to prevent someone from going into deep, deep shutdown. The DV system cannot create a very low heart rate (slowed way down) without recruiting fibers of the VV system. The VV usually moderates heart rate within a dynamic range. This moderating influence is removed if the body needs to go into the sympathetic response, and is reapplied (to calm the system down) when the sympathetic response is no longer needed. In order for the DV to create very low heart rates, it uses these VV fibers.

In the Beginning SE training, you learned a basic tool of trauma first aid. If a client starts to go into the trauma vortex and flood, have them look at you and bring them back to orienting. As you touch their arm and speak to them, "Look at my face", "Open your eyes and look at me," you are demanding they use as much of their VV as they can in that moment. Even if they have a tiny bit of VV capacity, you are asking them to use it now. The DV slows the heart rate to dangerous levels with recruitment (hijacking) of the VV fibers; social engagement keeps the VV functioning and prevents a person from going into deep, deep shutdown.

Prodromals and Pre-prodromals

Another way to work with syndromal patterns is to work with the prodromals and “pre-prodromals” of the symptoms. A prodromal is an early symptom or sensation indicating the onset of a syndromal “attack”. For example, a common prodromal for migraines is visual disturbance, such as colored flashes, which indicate to the migraine sufferer that a migraine is imminent. Sometimes the migraine can be interrupted if action is taken, such as taking pain medication, as soon as the prodromal symptom appears. Peter Levine coined the term “pre-prodromal” to describe the subtle symptoms that arise even prior to the prodromal symptoms.

As we know from other SE work, the earlier in the destabilization process we can intervene, the more options are available to interrupt habitual patterns of disorganization. In working with syndromes, if we can help the client notice the earliest indicators that their system is beginning to move into habitual syndromal patterns (pain, migraine, fatigue), the more options will become available to make other physiological choices.

Focused tracking of sensation by the client, as well as practitioner observation (visually or through touch) to identify these pre-prodromals provides an opportunity to work with symptoms as the earliest indicators of movement into the trauma vortex or into physiological disorganization. By helping the client re-introduce coherence at these early stages, overall stability can be supported and built in otherwise disordered systems.

Sequence of Recovery and Resolution

To track clients through these complex renegotiations, it is helpful to understand which system is operating or returning to function. The general sequence of recovery is dorsal vagal shutdown (DV) to sympathetic arousal (SNS) to ventral vagal social engagement (VV). When sympathetic and dorsal vagal activation occur concurrently, the freeze can be dampened through the ventral vagal system, though resolution occurs by completing incomplete defensive responses. As the organism moves up and out of the dorsal vagal state, both defensive orienting responses and boundaries are restored. In general, more VV signs appear as a person moves into lower and lower energy wells. One can get dorsal vagal shutdown in the absence of sympathetic arousal (e.g., fainting at the sight of blood). However, most cases of DV shutdown involve an initial threat, and a sympathetic response to the threat.

One can override a shutdown state in order to function day to day, but spontaneity is lost, and the person functions chronically “on automatic”. Starving children are often in dorsal vagal shutdown; they appear like the “living dead”, and lack spontaneous responses. Chronic dorsal vagal stimulation can cause loss of muscle tone (collapsed, mushy).

While in most cases as clients come out of the dorsal vagal state, sympathetic activation emerges, there can also be other scenarios:

- DV to SNS to V V: A shutdown state can change to a highly activated state (DV to SNS). Following deactivation, there can be orienting, and then the social engagement nervous system emerges (SNS to VV).
- DV to V V: A shutdown state may resolve directly to the client wanting contact. Sometimes a person transitions from DV to VV, but generally as the session progresses, deeper DV states appear, which may follow a different sequence of resolution.
- SNS to V V: A high sympathetic state may shift to the client wanting contact and social engagement.
- V V to DV: A socially engaged client is buffered against DV shutdown.
- V V to SNS: A socially engaged client is less likely to be activated (to experience high sympathetic tone).

Discharge occurs as the client moves from sympathetic to parasympathetic states. Both systems are involved in discharge in ways that are not yet fully understood.

Common Triggers: Sympathetic to Dorsal Shutdown

- “Need to know”: DV state occurs when the source of stimuli following an intense arousal of danger cannot be identified. A common example is earthquake, when the source of intense movement is so global that it cannot be identified as coming from a specific direction.
- “Not able to complete”: DV state occurs when there is physical obstruction of the aroused sympathetic activity. A common example is car accidents in which the SNS-produced urge to fight or flee is thwarted.
- Simultaneous arousal of 2 or more incompatible tendencies: For example, a frozen shoulder developed after a person helped at an accident scene; they reached toward the key to turn off the car, but then observed a horrifically injured child (the competing impulses here were altruistic helping and pulling back from horror).

Scope of Practice and Syndromes

Illness can mimic trauma, and trauma can mimic illness. Syndromes can be particularly challenging in this way, because a client's symptoms may in fact be a combination of illness and traumatic stress symptoms. It is important to make sure the client has been properly assessed from a medical perspective to ensure you are not overlooking symptoms of a disease or disorder that needs medical treatment. Additionally, appropriate treatment of the medical aspect of a disorder can clarify which symptoms are more appropriately addressed via SE.

Having a good network of medical and complementary care practitioners is an essential part of working with the most challenging trauma cases. It is imperative that you work within your ethical and legal scope of practice as you assist your clients. Most complex syndromal clients will need a team of practitioners of various kinds, since their symptoms and treatment are so complex. At the same time, you can be beneficial to these clients by helping them focus their care within the modalities that will be

most helpful to them. The lack of containment in their organismic function often manifests behaviorally as uncontained seeking of treatment from a multitude of practitioners. As we know from the material presented above, constant stimulation of the physiology, even by well-intentioned health care providers, can produce destabilization of the client's system. Recommend 'more is less' when working with referrals to other modalities.

Case Management of Syndromes

Tracking the progress of clients with syndromal patterns is challenging because the client's symptoms tend to vary even when no treatment is being received. For this same reason, it is also very difficult to assess the effectiveness of your SE interventions on a session-by-session basis. Case management for syndromes is an exercise in looking for overall trends in your clients' recovery.

Some common benchmarks can be used to assess whether a client is moving toward a more balanced level of function:

- There is movement from incoherence to coherence, and from dysregulation to resiliency.
- The body is healing, and returning to greater coherence, as the heart rate and lungs reestablish coherence. The body remains incoherent when respiration and heart work at odds with each other.
- Resiliency is restored when the client can work from a higher order of functioning, and can contain higher energy states without destabilizing and returning to habitual syndromal patterns.
- Keep in mind that the sympathetic response to fight or flee uses lots of metabolic energy. It also takes energy to come into self regulation. It's important to move more slowly in your work with syndromal clients than with others whose physiology has greater inherent stability. When you can begin to work at a more usual pace with syndromal clients, and they don't experience excess fatigue or recurrence of symptoms, this is an indicator that their system is becoming more resilient and organized.
- As the recovery process progresses, there is an increased capacity to reorganize, and the system moves toward larger and larger energy wells. This effectively means you can do more work in a single session, and still see good integration and orientation.
- Due to the high level of disorganization of the physiology, syndromal patterns tend to take a long time to fully resolve. You are more likely to be measuring recovery time in many months or years, rather than weeks or a few months.
- It is relatively uncommon for syndromal symptoms to improve in a linear way. Rather, you will see a general trend toward improvement, with ups and downs along the way:
 - The duration of symptoms lessens (e.g., migraines last a day instead of two).
 - The frequency of the symptoms lessens (e.g., migraines occur once per month instead of once per week).

- The severity of symptoms lessens (e.g., a chemically-sensitive client reacts less strongly to exposure to allergens).
- Recovery time after triggers is shorter (e.g., a chemically-sensitive client has a few hours of symptoms after an exposure, rather than days or weeks).
- Watch for arousal (even of pleasure) while on medications.
 - Arousal can trigger alarm and shutdown.
 - Syndromal clients tend to be particularly sensitive; be aware that some medications may be activating in the standard dose for certain patients.
 - Changes in medication can act as triggers/stimulation.
 - Watch for alienation from providers of medication. Relational alienation can result in the client refusing to take their medication.
- Be aware of arousal or activation from the environment, or from diet.
- Spiritual practices - some may help, and some may cause further dissociation. It is relatively common for people with highly dysregulated systems to escape into altered states as a way to manage their activation.



EYE WORK

Overview

Working with the eyes can be a very potent way to access deep patterns of dysregulation in the client's physiology. The eyes are inextricably linked to orienting and self-protection, and will often be strongly affected by traumatic stress disturbances in the physiology. Eye work directly interacts with the bi-directional ventral vagal system (receives/responds), and can address incomplete orienting and defensive responses in the "front end" (head, neck), as well as in the rest of the body. There is a stronger relationship between the head and neck with the autonomic nervous system (ANS) than between other parts of the body and the ANS. Doing SE work with the eyes involves the same dynamic principles as you have learned previously: coupling dynamics, completion of orienting responses, and restoration of coherence and balanced function.

As we want to make sure not to overload a client when we work with their eyes (or any other part of the body), one eye work "rule" is:

It makes no sense to do eye work in any session until a little preliminary SE work is done.

In order to avoid adding stimulation to an already over-activated system, you will need to move through 1-2 cycles of titration, pendulation and discharge before adding any external stimulus, such as eye work.

We are looking for over- and under-coupling within the eye movements themselves, but also with the coordination between eye movements and movements of the head and neck. The eyes and ears are the "front end" of the nervous system, and are coordinated by the ventral vagus. The aim of eye work is to engage the eyes with interactive movement that encourages shifts within the ANS, particularly within the ventral vagal system.

CAUTION: The stimulation of the physiology provided by working with the eyes is very direct. It is critical that you not overwork the client's system by overstimulating them with too many repetitions of eye movements. It is important to always monitor the client's activation as you do this work, and closely track their capacity to contain the amount of energy that is being mobilized. DO NOT overwork the eyes; this can drive the system into deeper dysregulation.

Working With the Eyes

- Work with glasses or contact lenses off.
- Work with one coordinate at a time. Eventually, you will have the client track your finger/hand movement through all angles and each quadrant of movement: vertical, horizontal, diagonal, all combined in a circular movement (like tracing the edge of a bowl); midline, left, right, upper, lower; from far to near, and near to far in each quadrant. It is rare that you will do more than a few of these movements in a single session, since most clients with eye disturbances cannot tolerate that much stimulation in a single session.

- Move slowly; pay attention to a client's activation level at all times. Having the client track these movements will gently stress and stimulate their system, so you must guard against over-stimulation throughout this exercise.
- Invite the client to "try to just let your eyes follow". This allows you to look at what the eyes, head and neck are doing as the client tracks the movement.
 - Hold one finger approximately 2 feet from the client's face, centered at the midline. Slowly they follow the movement. You will follow this same basic method for each of the angles and quadrants of movement.
- As the client follows your movement, notice what their eyes, head and neck are doing:
 - You will find fluid areas of movement (regularity, moving smoothly);
 - You may also find areas of movement that are under-coupled (eyes glazed, unfocused, blank, spaced out, not working together, losing track of your finger/hand).
 - You may also find areas of movement that are over-coupled (rapid eye movement, skips, glitches, fixation, "grabbing on", head moves with eyes).
 - You might see a combination of over- and under-coupling, i.e., over-coupling can exist in one direction and under-coupling in another.
 - If the eyes are over-coupled with head and neck movements, you will see movement of the head and neck even when you ask the client to track only with their eyes.
 - If the eyes are under-coupled with the neck, at a certain point in the movement, the client will stop moving their head and track only with their eyes.
- Each time you observe a change (i.e., in head, neck or eye movements), ask the client to stop and rest. Their system has been stimulated, and now you need to allow time for their responses to complete and integrate.
- If the client is feeling fatigued, or if their movements are becoming more and more uncoordinated, their system has probably been over-stimulated and you need to stop.
- When there is greater resiliency in the movement of the eyes, and between the eyes and head/neck, you can put a bit more demand on the system by having the client track a figure eight movement that encompasses all angles and quadrants of eye movement in a single, slow sweep of movement.
- The movements of your finger/hand are symbolic of something coming at the client and may evoke defensive responses. If you see those types of responses arising, take a moment to track and ask "What happens right here?" See if the client can get a sense of the movement impulse that is evoked; this may further reconnect them with their protective responses.

Learn to notice subtlety in the eyes' responses. Do the eyes narrow in any quadrant to assist with better focus? Do the pupils dilate, indicating sympathetic activity? Is there vibration? Is there a connection between the eye movement and muscle constriction in the neck? At the same time, you need to be able to focus on the bigger cycles related to eye movements. What is the overall trend in the movements? What are the cycles of completion for under- and over-coupled areas? Notice which finger movements

provoke reactions (i.e., a jerk of the head), and how those reactions change over time. Spatial fixation tends to indicate where a boundary rupture or breach occurred.

Again, the focus is on completion of incomplete responses – anywhere in the system. For example, you may notice the client's eyes widen, head pulling back (recoiling movement, spine tightening) and a snarl in their expression as a defensive response comes up. Completing these responses can re-open the client to additional self-protective responses.

As you move through rounds of testing and stimulating a particular eye coordinate or quadrant, and then "just resting", take time to notice what changes are occurring, and when to do another round or just wait. If your client starts looking around on their own, it is almost always a sign to do nothing more for now. If they are looking around, the ventral vagal system is engaged; allow time for integration before doing any more cycles of eye movement.

As in any SE session, ask your client what they are noticing and what's shifting in their internal experience. Always look for activation, discharge, coherence, and ANS shifts. Toward the end of the session, as the client begins to orient and look around, have them also become aware of inner movement, sensations, and feelings.

NOTE: If a client has had past medical procedures or direct eye injury, their eye(s) may be very sensitive. Any movement toward the eye is often quite challenging. In some cases, the client may need more medical treatment, but has been avoiding it due to their oversensitivity. You may need to work with the eyes in the way outlined above to reduce their sensitivity and restore aliveness, so that they can take the next medical step.

Coherence and Reorganization

As you proceed with eye work over time, you should see a re-emergence of coherence in a client's eye movements and in the coordination between the eyes, head and neck. This work is particularly helpful when orientation has been disrupted, for example, as a result of a motor vehicle accident. As you work, monitor the breath and support any increase in coherence between the breath and the muscle system, particularly in the neck and shoulders. You may need to provide some gentle touch and support to the base of the skull if the over- or under-coupling has been particularly pronounced in the relationship between the eyes and the movement of the head.



TOUCH, COHERENCE, AND CONTAINMENT

Some traumas locked in the body may not be reached by tracking sensation. Touch may be needed to help bring healing more rapidly and at deeper levels than can be accomplished through non-touch methods. Some of the deepest shock experiences held in the body occur when we are so young that our brains are not yet sufficiently developed to process those experiences cognitively. These early experiences are held primarily as somatic “memories” or habits, which can often be most effectively accessed by working directly through the language of touch.

In addition, for many of us, our earliest experiences of being soothed, nurtured and held in bonded relationship happened via touch. Obviously, this is unfortunately not the case for everyone, but chances are that our earliest experiences of touch were positive. Particularly when working with early developmental disturbances, sometimes touch is an essential part of the renegotiation process.



“Traumatic memories persist primarily as implicit, behavioral and somatic memories, and only secondarily as vague, overgeneral, fragmented, incomplete and disorganized narratives...These memories change as people recover from their P TSD.”

— van der Kolk,
“PTSD and the Nature of
Trauma” in Siegel (2007), *Healing Trauma*

Diaphragms as Containers of Affect and as Self-Regulators of High Energy States

Introduction

The SE model of body diaphragms is different than that used by other systems. From the SE perspective, body diaphragms are seen as containers of affect, as well as primary instruments of self-regulation for managing deep shock states and their associated high-energy states. This is a unique perspective that extends the osteopathic view of body diaphragms into a trauma-based model.

We will be working with body diaphragms in detail in Advanced 2. Here, an introduction is provided in the context of working with the diaphragm system in a general way, as a means to enhance coherence and containment. This can be particularly useful as clients with deeply dysregulated systems begin to find greater levels of equilibrium in their function. Working with the diaphragms in the context of enhancing the client’s newly-initiated self-regulatory capacities can support the ongoing change process.

Main Diaphragms that “Contain” Affective Experience

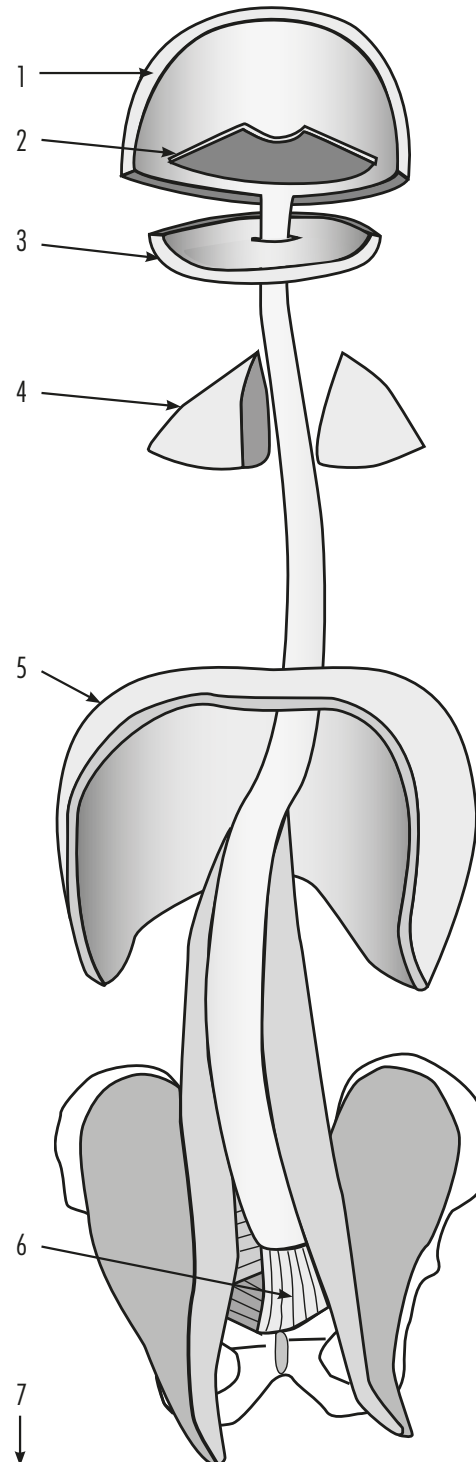
1. Calvaria - domed top of the head
2. Tentorial membrane – membrane at the floor of the cranium, which attaches to the interior of the back of the head/base of skull
3. Cranial Base

4. Thoracic outlet/shoulder girdle – shoulders, clavicle, upper thoracic vertebrae, apex of lungs
5. Respiratory Diaphragm
6. Pelvic floor
7. Soles of the Feet

THE SEVEN BOWLS AND DOMES OF THE BODY

- 1 Dome of the skull
- 2 Dome of the tentorium
- 3 Bowl of cranial base
- 4 Dome of the apex of the lungs
- 5 Dome of respiratory diaphragm
- 6 Bowl of perineal diaphragm
- 7 Bowl of the soles of the feet (not shown)

Drawn from: *"The Heart of Listening"*
by Hugh Milne



The primary focus in working with these diaphragms at this stage will be on supporting coherence as it returns. You may feel the restoration of pulsation from the breathing rhythm within one diaphragm first, and then in various diaphragms in combination.

It is uncommon to work with only one diaphragm. They work together cooperatively, so there will be a natural response in each diaphragm as the others change. It is again important to monitor the client's activation levels to ensure you are not provoking too much change in too short a period of time.



STUDENT SELF- ASSESSMENT QUESTIONNAIRE

Advanced: Module 1

This self-assessment questionnaire is intended as a review of the concepts and practical skills covered in each module, and as guidance for focusing your consultation sessions, and review questions of faculty in future modules. The concepts and skills listed below are those that you are expected to have learned in this module. For each of the listed skills or concepts, if you do not have at least a basic understanding, or feel at least somewhat proficient in being able to apply those skills, you should consider focusing more specifically on those topics in your consultations with faculty or approved consultation providers. Each module builds upon the knowledge gained in previous modules, so any gaps in your understanding will only make future material more challenging to learn.

You may want to return to the questionnaires for previous modules as you progress in the training, since your understanding of basic concepts will change as you gain in experience.

PART 1					
Circle one of the numbers on the scale to indicate your depth of understanding of each of the concepts listed below.					
	Don't Understand	Still Unclear on Some Aspects	Basic Understanding	Good Understanding	Understand Well
The SE concept of coherence, particularly in relationship to syndromal patterns	1	2	3	4	5
The SE concept of containment, and its importance in working with highly dysregulated systems	1	2	3	4	5
Polyvagal Theory					
Interplay between dorsal (DV) and ventral vagal (VV) systems and sympathetic (SNS) system	1	2	3	4	5
Which body responses are primarily controlled by DV, VV or SNS	1	2	3	4	5
The role of neuroception in response to threat	1	2	3	4	5
Key concepts of working with syndromes					
Resilient, reciprocal systems vs. non-reciprocal systems	1	2	3	4	5
The basic SE model of trauma-related syndromes	1	2	3	4	5
The Energy Wells model of working with syndromes	1	2	3	4	5
The SE concept of titrated stimulations, used with syndromes or highly dysregulated systems	1	2	3	4	5
The SE concept of "pre-prodromals"	1	2	3	4	5
The SE model of working with the eyes	1	2	3	4	5
Basic overview of the SE model of body diaphragms	1	2	3	4	5
Other _____	1	2	3	4	5

PART 2

Circle one of the numbers on the scale to indicate how proficient you feel about being able to apply each of the skills or concepts listed below.

	Not at all Proficient	Lacking Proficiency	In the Middle	Somewhat Proficient	Very Proficient
Recognize when coherence is increasing in the client's system(s)	1	2	3	4	5
Can support and encourage restoration of coherence	1	2	3	4	5
Recognize when the client's capacity for containment is sufficient to work more deeply with disorganized systems	1	2	3	4	5
Recognize signals of dorsal and ventral vagal response	1	2	3	4	5
Can evoke ventral vagal response	1	2	3	4	5
Can observe client's pendulations well enough to recognize movement from one energy well to another	1	2	3	4	5
Can facilitate movement from one energy well to another	1	2	3	4	5
Can manage a session well enough to keep titrations and pendulations small when working with syndromal patterns	1	2	3	4	5
Can recognize prodromals and pre-prodromals	1	2	3	4	5
Can recognize at least 3 sequences of recovery of DV, VV, SNS	1	2	3	4	5
Can identify my appropriate Scope of Practice, particularly in relation to working with syndromes	1	2	3	4	5
Have a basic understanding of the case management of syndromes	1	2	3	4	5
Working with the eyes	1	2	3	4	5
Other _____	1	2	3	4	5



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