Somatic Experiencing®

Intermediate Year

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Intermediate Year
Introduction/Overview

In the Intermediate year, we will focus on working with specific categories of trauma. Events that are traumatically stressful have a range of different "personalities", and tend to provoke a variety of physiological responses, defensive impulses, and strategies to cope with the particular survival dilemmas that are constellated by specific traumatic circumstances. Different categories of trauma quite often have certain hallmarks that give us indicators for where to focus in the trauma renegotiation process. The material learned in the Beginning year will be applied in the Intermediate year in the specific context of different categories of trauma, thus bringing a more complete understanding of the variety of interventions that are possible through the SE building blocks.

Categories of Trauma

"The severity of traumatic events cannot be measured on any single dimension; simplistic efforts to quantify trauma ultimately lead to meaningless comparisons of horror. Nevertheless, certain identifiable experiences increase the likelihood of harm. These include being taken by surprise, trapped, or exposed to the point of exhaustion. The likelihood of harm is also increased when the traumatic events include physical violation or injury, exposure to extreme violence, or witnessing grotesque death. In each instance, the salient characteristic of the traumatic event is its power to inspire helplessness and terror." — Judith Herman, MD, *Trauma and Recovery*

Working with various categories of trauma demands that the practitioner be skillful in managing the pace of the renegotiation process in a different way than was possible during the Beginning year. Working with the most challenging categories of trauma will strengthen the therapist's fundamental confidence in the SE process, and their trust that organismic capacity expands with titration, which truly means working with the "least possible activation". When enough time is given for that smallest amount of activation to work its way through the system (via pendulation), then the client's resiliency and capacity increase dramatically.

The material in the Intermediate year provides an opportunity to understand the complex interaction between survival responses, nervous system dysregulation, SIBAM and its related coupling dynamics, as well as the potentially complex relationship between different types of trauma. For example, a single motor vehicle accident, and the subsequent treatment for injuries sustained in that accident, may have within it the following categories: physical injury, failure of physical defense, inescapable attack, horror, and surgery.

SE Categories of Trauma

There are a number of different models used in the trauma recovery field to describe different categories of trauma. The SE model uses a list of categories that reflects the SE perspective of working with trauma, and groups types of traumatic experiences together according to the similarity of the physiological disturbances produced within that category, as well as by the trauma renegotiation strategies that work most effectively with those types of traumatic experiences. An example is that of the High Impact/Failure of Physical Defense category. Within this category are contained the types of traumatic experiences that involve high speed and high impact as the source of trauma (e.g., car accidents), as well as experiences in which the body's own capacity for self-protection is overwhelmed (e.g., falls). These different types of traumas share similar characteristics in the symptoms they produce, and the primary SE interventions used to renegotiate them are the same.

Below are the categories and sub-categories of trauma that are used in the SE model. The sub-categories are listed and discussed in more detail in the text if additional characteristics differentiate them further within the main category. The categories are grouped together within the module in which they are presented. Some sub-categories within a main category are presented in different modules, and this is also noted in the list on page I1.7.

Intermediate Module 1

Global High Intensity Activation (GHIA)

Pre- and Perinatal Trauma
(Fetal distress, birth trauma, early surgeries)
Anesthesia
High fevers
Suffocation, Choking, Drowning

High Impact/Failure of Physical Defense

Falls
Acquired Brain Injury

High Impact and Motor Vehicle Accidents (MVA) ***(Presented in Intermediate Module 2)***

Inescapable Attack

Animal Attack
Escape Inhibited

Rape/sexual abuse ***(Presented in Intermediate Module 2)***

Intermediate Module 2

Physical Injury

Surgery
Poison
Burns

Note: Failure of Physical Defense: High Impact and Motor Vehicle Accidents and Inescapable Attack: Rape and Sexual Abuse are also presented in Module 2

Intermediate Module 3

Natural and Man-made Disasters

Natural Disasters
Horror
Torture, Ritual Abuse, War, Terrorism

Emotional Trauma

Scope of Practice

As a practitioner, you should work only with categories of trauma for which you are legally and ethically qualified. Trauma first aid and basic SE work to promote better self-regulation typically falls within acceptable guidelines for any SE practitioner. Categories of trauma that have a strong psychological component, such as emotional trauma, will generally require that a practitioner have training and expertise in psychological interventions. Likewise, trauma categories that include potentially severe physical injury may require a practitioner who has appropriate knowledge of physical care methods and contraindications in order to ensure the safety of the client. As noted in Beginning Module 3, the following guidelines will help you maintain appropriate scope while integrating SE into your existing practice.

Keeping the Appropriate Focus on Scope While Integrating SE into Your Practice

The following questions can be used to assess whether or not a bodywork or psychotherapy context is most appropriate, or whether a referral or team approach is needed for a particular client:

- What are the primary dynamics of the client's symptoms: physical, emotional, developmental, psychological, relational, or a mix?

- Does your scope appropriately include the needed elements to effectively deal with these dynamics?
    - Could it include some of the elements if you have supervision or other practitioners involved?
    - How will you and the client determine the boundaries of appropriate scope?

- Can you access the symptoms through the:
    - Body (for bodyworkers and movement educators)?
    - Psychotherapeutic relationship (for psychotherapists and counselors)?

  Or, will other forms of understanding and intervention be needed?

- Can the client's symptoms and responses be adequately discussed using:
    - Body therapy language rather than psychotherapeutic language (for bodyworkers and movement educators)?
    - Psychotherapeutic, somatic language (for psychotherapists and counselors) - or is the language of physical repair needed?

- Are the client's resources adequate to maintain appropriate scope boundaries as the SE work proceeds?

Secondary Trauma, Self-regulation, and Self-care

As we discuss various categories of trauma during the Intermediate year, we will be focusing on difficult things that happen to people. As we attend in detail to the challenges faced in traumatic experiences, it is essential that you attend to your own self-regulation and self-care. Reprinted below are the recommendations made in the Beginning 1 Module to support your own self-regulation during the SE training program. By working to increase your capacity for self-regulation, you will be increasing your overall capacity and competency to practice SE.

Self-regulation and self-care

Discussions of trauma can provoke our personal unconscious and preverbal material. As part of the self-assessment process, students are encouraged to be sensitive to their unique experiences during the training, and to get adequate support (from assistants, sessions, consultations, peers, etc.) to ensure that their own personal process does not overwhelm their capacity to be available for the training.

The following are common behaviors, sensations, and indicators of activation that may occur during or after class:

- Destabilization can often arise during transitions: arrivals and departures;going to/from breaks; beginning and ending class exercises.
- If you feel yourself becoming irritable, anxious, sleepy, or spacey, you may be activated.
- Ruminating; projecting; having strong desires to flee or isolate; excessive anger or criticism toward the training, the teacher, assistants, fellow students, or FHE staff can sometimes be signs of activation.
- If you find yourself doing some of your favorite self-soothing activities in somewhat obsessive ways, this may also indicate that your activation level has risen without you being aware of it.
- It is often easier to manage your activation when you are the practitioner than when you are the observer in triad practices, or when you're observing a demo in front of the class. It is especially helpful to track and take note of your own somatic state when in the observer role.
- Feeling disconnected or unable to ask for assistance can sometimes be a sign that you have moved into a freeze or immobility response.

"Traumatic Countertransference: *Trauma is contagious. In the role of witness to disaster or atrocity, the therapist at times is emotionally overwhelmed. She experiences, to a lesser degree, the same terror, rage, and despair as the patient… Hearing the patient's story is bound to revive any personal traumatic experiences that the therapist may have suffered in the past…The therapist also empathically shares the patient's experience of helplessness. This may lead the therapist to underestimate her skill, or to lose sight of the patient's strengths and resources…As a defense against the unbearable feeling of helplessness, the therapist may try to assume the role of a rescuer…The more the therapist accepts the idea that the patient is helpless, the more she perpetuates the traumatic transference and disempowers the patient."*

— Judith Herman, *Trauma and Recovery*, pages 140-142.

Specific steps you can take during the training to increase your awareness of your own activation in its earliest stages, manage your activation, and increase your capacity for self-regulation:

- Check in with yourself on an ongoing basis to monitor your level of activation.
- Identify your particular style of acting out (or in) when activated. Before acting on impulses to flee or isolate, and before expressing anger directly toward others, take a few moments to check in with your sensations, and notice how activation may be driving your responses.
- If you tend to go into freeze or dissociation, it can often be helpful to have a trusted fellow student or assistant be on the lookout for your typical behaviors and states, so they can help bring your attention to them as they occur.
- Identify techniques in advance that help you to feel more present and settled (see sample exercise, page I1.9). Identify your personal resources, and use them in class as regularly as possible so that they become second nature.
- Assess your capacity to self-regulate in class, and take responsibility to ask for, and accept tracking help from, assistants.
- Come back to your felt sense. Ground.
- Get support from fellow participants and assistants.
- Develop strategies to enhance self-regulation.
- Move gently, breathe, take time to settle, limit continued stimulation (via sound, light, etc.).
- Understand that your responses might be delayed, and could occur outside of class. Be prepared to get support from friends and family, and understand that unexpected responses can be related to these delayed reactions.
- Try not to go into isolation.
- Focus on your activation level and symptoms in consultations or private sessions to increase your learning edge and professional competency.
- The required number of private sessions in each year of the training is the absolute minimum; more sessions are strongly recommended to increase skill in self-regulation. Self-regulation is a key behavior and skill in the practice of SE.

"The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation… Therapists who work with traumatized people require an ongoing support system to deal with these intense reactions. Just as no survivor can recover alone, no therapist can work with trauma alone."

— Judith Herman, *Trauma and Recovery*, pages 133,141

The following exercise can be practiced in the extended version presented here, or used in an abbreviated version as you move through each transition in the training (moving from client to observer in triad practice; moving back to the classroom after breaks; moving from the classroom to practice groups after lectures).

Notice the sensations of settling and take time just to be present to "arrive" – one molecule at a time. Then, notice the group field, the support and containing quality of that resource, and expand that awareness to the international SE field – building on the fact that there is an enormous amount of support and expertise as we take this journey into group field. Whenever you come back from a break, or the group has become activated by a discussion or disturbance in the environment take a moment to re-settle. You do this to develop a habit of checking your own activation and then settling yourself, as you would have to do in your own office when doing SE with clients. With this kind of exercise, group containment and group process become a constant source of teaching the awareness and embodiment skills so central to SE practice.
(Thanks to Nancy Napier for this exercise)

A special thank you to FHE faculty member Lael Katherine Keen, who wrote many pages of material on the trauma categories for this manual. In addition to Dr. Peter Levine's original material, the following FHE faculty contributed helpful information for this module: Dave Berger, Ariel Giarretto, Sonia Gomes, Kathy Kain, Gina Ross, and Raja Selvam .

Somatic Experiencing®

Intermediate Year

Module 1

Global High Intensity Activation (GHIA)

Additional Sub-Categories include:

- **Pre- and Peri-natal Trauma: fetal distress, birth trauma, early surgeries**
  Note: General information on working with surgery is presented in Intermediate 2 (Physical Injury section)
- **Anesthesia, High Fevers**
- **Suffocation, Choking, Drowning**

General Overview

The GHIA category involves massive stimulation and arousal of the entire central nervous system, which permeates all aspects of the physiology. In this state, the entire organism moves toward end-stage survival responses. The types of experiences that produce GHIA include fetal stress, electrocution, high fever, surgery with ether, surgery in infancy, and suffocation/drowning. There is a strong tendency for these types of experiences to overcouple with each other, since all involve a global physiological response.

Key Defensive Impulses and Typical Coping Mechanisms

(Also see individual sub-categories below)

Because the system was so overwhelmed, there is often little indication of specific defensive response until activation levels have decreased dramatically. Over- and undercoupling are, for the moment, the key survival strategies. Managing her responses to stimuli will feel critical to the client, since this is the primary coping mechanism used to keep her system from moving into overwhelm, and its concurrent fragmentation, hyper-arousal and dissociation. As the physiology re-learns its self-regulatory processes, and activation levels decrease, specific survival responses will emerge and begin to differentiate. This indicates that resiliency is being restored.

Primary Characteristics and Hallmarks–GHIA

- Massive arousal, with little capacity for self-regulation. System is fully "on", or fully "off", with little response available in between these two extremes.
- GHIA tends to become the underlying pattern of the nervous system; client tends to have much less resiliency.
- Usually includes dissociative content. SE work cannot be done at the body level if the client is too dissociated.
- There is often a strong relationship between GHIA and attachment/ bonding difficulties. The polyvagal theory helps explain how GHIA and the lack of bonding are interrelated; this will be covered more fully in the Advanced year.
- Client needs appropriate containment for this high level of activation.
- Strong tendency to overcouple with other types of trauma, particularly other forms of GHIA. There is no such thing as working with a single traumatic experience within GHIA – the organism responds globally to each stimulus.

Common Symptoms

The symptoms for this category are often vague, and tend to include multiple body systems. There can be a tendency toward "energy storms", in which symptoms escalate dramatically and with little in the way of apparent triggers. The person may feel flooded with energy and have strong psychosomatic symptoms (particularly having to do with the viscera or respiratory function), or they might have extreme fears, beyond what their history would indicate. There could be extreme sensitivities to the environment, to sounds, smells, and other external stimuli. GHIA clients are prone to debilitating physical symptoms , such as migraines and pain syndromes.

Working with GHIA – General

- Working with GHIA tends to be a lengthy process. The overall system is so dysregulated that the natural mechanisms that restore resiliency have trouble taking hold. The theme for GHIA is titration, titration, titration. Resolution may require work from a team of various practitioners to address the complex physiological/metabolic issues, in addition to SE work.

  Note: The SE Advanced year will focus more fully on this category, particularly in relation to syndromes, and you will have additional opportunities to refine your skills in working with this kind of severe dysregulation.

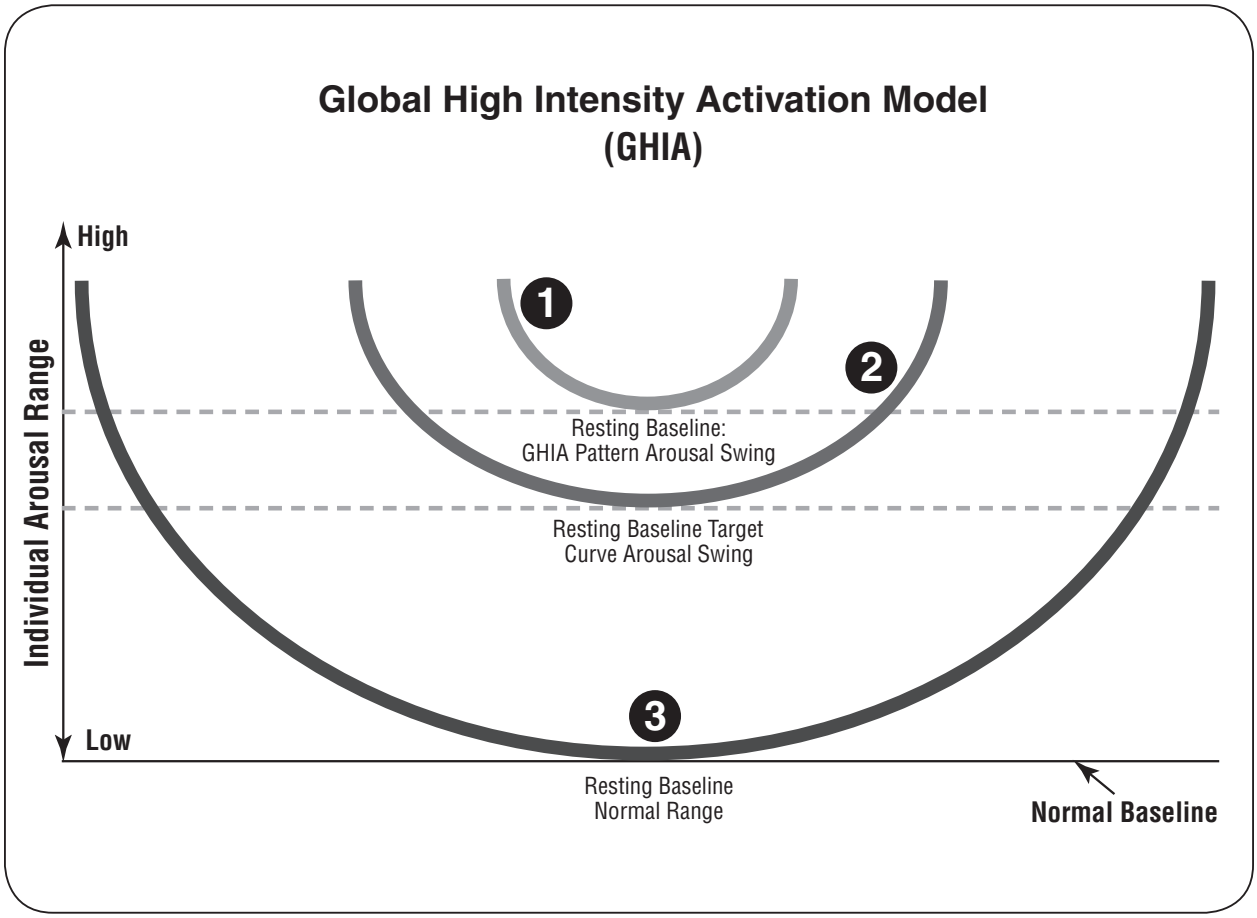
- GHIA is a form of massive and simultaneous over- and undercoupling. Symptoms and client responses can be changeable, confused, and confusing. The client's system changes even with no apparent stimulus, which can make it difficult to understand how your work is affecting them. It is important to focus on the overall trend in the progression of the client's symptoms, and not get lost in the details of their responses that come and go.

- Clients will need to learn self-help tools to recognize the GHIA pattern and work with it on an ongoing basis. Most typically, clients experience the dysregulation on a daily basis, and will already have developed effective self-help tools that you can help them refine and make more effective, so as to support their overall healing process.

- Help the client establish clear and well-organized cycles of charge and discharge.
  - Each pendulation should have a similar duration and intensity.
  - The client should be able to return to the "mainstream" between pendulations.

- Helping the client build this capacity will take a long time, because you are changing a pattern that underlies all the workings of their nervous system.
- Perseverance and patience will be needed. It is worth noting that once you have helped the client become more stable, many of the symptoms that they brought to treatment may already have been resolved.

- As much as possible, uncouple one activation process from another, and separate different trauma vortices from each other.
- Help clients uncouple, one by one, all the elements that trigger the entire system into activating all at once. Help them practice being able to have a small response and stop, and another small response and stop. This practice is very helpful in uncoupling the massive overactivation from simple stimuli.
- Look for a reduction in activation, no matter how small. This shows the beginnings of the capacity for self-regulation. Many times this dip in activation occurs, and the client (or therapist) gives it little attention because it is so small (such as a single deep breath). Learn to notice these subtle cues that indicate that the system is starting to modulate its responses.
- The art of working with GHIA is to be able to recognize and take advantage of these small shifts in the system, which give footholds for larger changes as the capacity to manage higher levels of arousal increases and the level of activation decreases.



Sub-Categories of GHIA

Pre- and Peri-natal Trauma
(Fetal distress, birth trauma, early surgeries)

Key Defensive Impulses and Typical Coping Mechanisms of Pre- and Peri-natal Trauma

- Key physical defensive responses from the pre- and peri-natal period typically relate to the earliest spinal reflexes. A kind of "larval swimming movement", centered in the spine and having little connection to movement in the arms or legs, is often a sign of early attempts at defense. Since more mature and effective reflexes should replace early defensive reflexes, when an early reflex becomes visible, we may be seeing signs of disturbance, or lack of integration of that reflex.
- Neither the fetus nor infant have an effective physiological method for self-soothing and managing states of high activation. As activation increases, the the organism's last strategy is to try to contain the high activation, most often through patterns of highly charged tension in the viscera, skin, eyes, and spinal column.

Common Symptoms of Pre- and Peri-natal Trauma

- Sensations of electric current in the body; the feeling of energy that is so intense that it is almost intolerable; humming or buzzing in the ears, or the equivalent feeling in the body.
- Activation in the eye segment. Activation in the eyes may have to do with early bonding trauma.
- Tension patterns around the umbilicus and in the viscera.

Working with Pre- and Peri-natal Trauma

- Because of the early nature of these traumas, the first order of business is to help the client create a container that is sufficiently deep and secure that s/he can touch into activation without dissociating.
- Work to build the capacity to pendulate, and move into the discharge state in a titrated manner, without going into overload and freeze.

Primary Characteristics and Hallmarks

In the fetus and infant, neither fight nor flight are possible, so active defensive mechanisms are limited. Also absent is the capacity for self-regulation and self-soothing. Infants' nervous systems are still immature and not yet physiologically capable of managing activation. Babies are born with fully functioning dorsal vagal systems, and their sympathetic nervous systems develop and begin to function only after birth. The caregiver acts as the ventral vagal (soothing) system until the infant's nervous system is myelinated and can begin to regulate itself.

Several decades ago, it was common practice to perform surgery on infants without anesthesia. At the time, babies were thought to feel no pain, so it was not understood that there was any need to anesthetize them. In the 1940s, David Levy did research on trauma in hospitalized children, and found that they showed the same degree of post-traumatic stress syndrome as war veterans.

Note: Information on preparing children and adults for surgery is presented in Intermediate Module 2, in the section on Physical Injury.

- Have the client notice resources at the body level.
- Support the client to develop a good "witnessing presence", to be able to contact early trauma without regressing, and to experience deep emotions and stay present in her body.
- It is particularly helpful to work in small enough increments that the client has success in working with, discharging, and integrating some of their more recent traumas.
- There comes a time in the client's process in which pre- and peri-natal issues begin to come forward in bigger pieces, with longer, more complete sequences. This is usually an indication that the client is ready to work at a deeper level and can reach resolution.
- There are two important questions that should be asked on an ongoing basis when working with pre- and peri-natal issues:
    - Is the client able to contact these issues and energies and stay present in his body, pendulating, titrating and integrating what emerges?
    - What kinds of changes are happening in the rest of the client's life as the two of you move into this process together? Is the client functioning at a higher level? Is the client regressing?

  Remember that our goal is the renegotiation and resolution of traumatic symptoms, *not* regression.
- Use the "Vooo" sound to work with visceral constriction.
- Stay alert for indicators that the viscera is beginning to come out of freeze: burps, stomach rumblings, peristaltic sounds, softening of the abdomen. Such signals are generally a good sign, indicating that the parasympathetic nervous system is functioning.
- Watch for small movements of the jaw. These movements can indicate a rooting or suckling reflex is emerging. Go slowly, as this restoration of primitive reflexes can release a lot of bound energy.
- Watch for, and support, pushing movements involving the head, feet and legs. Again, work in small titrations so that bound energy is released slowly.

Anesthesia

Receiving anesthesia does not automatically mean someone will have anesthesia trauma. However, if the person is highly activated at the time the anesthesia is administered, this will increase the possibility of a global high activation response that will be coupled with the anesthesia state. Children are particularly at risk for this, as are those whose physiology is already highly dysregulated. Anesthesia produces a state of discontinuity, a kind of chemically-induced altered state, with the associated distortions of perception that typically accompany altered states. When ether was used as an anesthetic, it tended to produce these types of extreme states, and has a high probability of being coupled with the global high activation state.

Obviously, anesthesia trauma can be coupled with the surgical process itself. Different anesthetics have different effects on the physiology: some paralyze the muscles, others create numbing in specific areas, while still others cause amnesia. The specific effect of the anesthetic is part of what may need to be renegotiated in the recovery process. For example, completion of thwarted physical defensive responses is often part of the renegotiation process when muscle relaxant anesthetics have been used. This will be covered more fully in the Physical Injury category in Intermediate Module 2.

In this section, our focus is on anesthesia when it has coupled with global high activation – which places it within the GHIA category.

Working With Anesthesia

- Working with anesthetized states that have produced GHIA, or are coupled with high levels of activation, is a complex process. Dr. Peter Levine recommends that in the beginning, the SE therapist work with anesthesia states only with consultation.
- Working with anesthetized states related to GHIA is a process of:
    - Helping the client manage the high levels of activation associated with the altered state of the anesthesia.
    - Working with re-association, restoration of continuity (between discontinuous states of consciousness), and sequencing in more normal awareness.
    - Helping the client differentiate: the activation from the anesthesia state; the distorted perceptions from more normal awareness; the coupled elements of the anesthesia and surgical experiences.
- As in working with the freeze state, the practitioner can assist the client in cycling through the anesthesia states by providing clear feedback about autonomic shifts, and by supporting the client to use their resources to manage the activation underlying the "freeze" state of the anesthetic.
- Working with anesthesia-related disturbances is sometimes similar to working with the after-effects of a high fever. (See the following section for further information.)

Primary Characteristics and Hallmarks–Anesthesia

- If the client has unresolved trauma related to anesthesia, there will be moments when elements having to do with the anesthetized state will appear during her sessions.
- Possible signs that what is appearing is related to an anesthesia state that has not reintegrated into normal awareness:
    - Diminished muscular tone in the client's face.
    - The client's skin becomes pallid or even greenish.
    - Therapist or client smells the odors of the hospital, the operating room, or the anesthesia itself.
    - The client appears to be in a slightly altered state.
    - Time seems to slow way down.
    - Client's eyes can appear glassy and staring.
- Anesthesia states tend to be fairly potent; it is not uncommon for the therapist to feel very drowsy, woozy, or dissociated when these states are arising. If you notice that you are feeling drowsy in cycles, notice if you are seeing the same cycles in your client's body indicators.

High Fevers

Like anesthesia, high fevers can produce a GHIA response, or couple with GHIA states, when high levels of activation accompany the fever. This most typically happens when a person is delirious with fever and experiencing distorted perceptions that are frightening. As with anesthesia, children and those with pre-existing GHIA are particularly at risk for these high levels of activation with the delirium of high fever.

What do high fever and anesthesia experiences have in common?

- Both will tend to create discontinuous states of awareness.
- When we are in a dissociated state of consciousness and become frightened, the fear may be "held" in the altered state of awareness, and thus are very difficult to access and discharge.

Working with High Fever Traumas

- In working with high fever trauma, the goal is first and foremost to help the client reconnect the discontinuous states associated with the high fever. The therapist acts as guide, witness and reassuring presence, as the client once again passes through the various altered states associated with the fever, but this time with a thread of continuity. The continuity is provided by the therapist's presence and the client's own sense of witness.
    - This is achieved by tracking the client, and paying special attention to any abrupt changes that appear in the client's physiological state. You'll know that you've found a discontinuity in the system when you see a sudden change in skin color, heart rate or breathing, or a change of expression on the client's face. The therapist's job, at this moment, is to help the client stay present, track, and eventually sequence these different states.
- The incomplete responses that we find when dealing with high fever trauma are the physiological cycles related to the fever that, for one reason or another, were unable to complete at the time. Changes of temperature, sweating, and fits of trembling are common. When these arise, help the client to stay present with them until they complete.

Primary Characteristics and Hallmarks–High Fever

- Fever is a natural process that is meant to cycle through the system and resolve itself. Potential traumatization may occur if the client becomes frightened of the intensity of physical manifestations that accompany the fever. This is when you will see incomplete responses (the cycles of the fever itself when the client fought against them) and fear that can become overcoupled with the altered state of consciousness, and be fixated in a dissociated state.
- Fear of, and bracing against, the cycles of the fever often happen when the sick person is left alone, gets frightened and there is nobody nearby to reassure him. Children are more vulnerable than adults.
- As the fever rises towards delirium, a certain quality of mental confusion will appear. The key to successfully renegotiating the fever is to surrender to this state of confusion (as with anesthesia), ride through the cycle with it, and return to normal.
- Do not leave a person alone who has a high fever. Stay close by where you can monitor what is happening, and come if he calls out. If he becomes delirious, stay there until the delirium has passed.

- Another common incomplete response is surrender to the mental confusion or delirium that can accompany the fever. It may be that the client was alone and frightened at the time of the fever, and mightily resisted the altered state. Now, with the presence of the therapist, and the knowledge that the altered state is a natural part of the fever, if the client can let go into the delirium, he will be able to go through it, and come out the other side—this time with the experience integrated internally.
- Out of body experiences frequently accompany high fevers. Out of body experiences are classic examples of undercoupling. The problem is not that the client had an out of body experience, but that he was frightened by the that experience, or felt that he never came back all the way.

Suffocation, Choking, Drowning

Working with Suffocation and Choking

- The work here is to contact, at the body level, the two conflicting impulses, and take time to fully feel the conflict and the opposite pulls of both. Since both impulses may have life or death value, it can be very activating for the client to stay present in the place between. He may need resourcing and support from the therapist to be able to do so. The conflict resolves when one impulse waxes stronger, wins over the weaker one, and the body breaks the stalemate and moves in a clear direction. It may also be helpful, at a later time, to return and explore the direction of the weaker impulse as well.

Primary Characteristics and Hallmarks– Suffocation Choking, Drowning

The common denominator for all forms of suffocation is the survival dilemma of struggle versus oxygen conservation. The primary impulse for defense is the very thing that most quickly uses the little oxygen that is left in the system when a productive breath cannot be taken.

- The therapist will know that s/he is getting close to this stalemate when s/he begins to see certain involuntary mechanisms appear in the client that indicate the dilemma is intensifying. Because staying with the conflicting impulses of struggle and surrender can be so challenging, the client will typically find methods to temporarily reduce the discomfort:
    - Coughing
    - Clearing one's throat
    - Swallowing
    - Breathing deeply
    - You will recognize that this is what is happening by the discontinuity that it brings to the client's process—for example, each time that the client begins to be aware of activation in the throat, he starts to swallow, and the activation recedes into the background. This reflexive action may also occur with more force than it would if it were truly coming from the involuntary, self-regulatory part of the client's system.
    - Work with this by asking the client to wait as long as possible before allowing the self-soothing impulse to happen, and then ask him to notice and track the underlying activation that appears.
- Sometimes it takes time and patience to reach the place where the client can feel the conflict.
- You may need to return to this place of conflict and stalemate a number of times for the client to succeed in discharging all the activation that is held there.

Working with Drowning

"Near drowning connotes an immersion episode of sufficient severity to warrant medical attention that may lead to morbidity and death… ***In the US:*** *Drowning deaths number more than 8000 per year, with 1500 of these deaths occurring in children…Despite preventive measures, the 1997 National Center for Health Statistics found drowning second only to motor vehicle collisions (MVCs) as the most common cause of injury and death in children aged 1 month to 14 years. In 3 states, Arizona, Florida, and California, drowning actually exceeded MVCs…A survey of 9420 primary school children in South Carolina estimated that approximately 10% of children younger than 5 years had an experience judged a "serious threat" of near drowning…Submersion-related injuries are the fifth leading cause of accidental death in the US in all age groups; incidence is approximately 2.5-3.5 per 100,000 population.* ***California reports approximately 25,000 ocean rescues on its beaches each year. True incidence of near drowning has yet to be defined accurately, however, since many cases are not reported.****"*

—Submersion Injury, Near Drowning, Suzanne M. Shepard, M.D., from www.emedicine.com/emerg/topic744.htm

5 Stages of Drowning

(These five stages were articulated by Raja Selvam.)

1. **Orientation to danger**—What was the first moment in which the client noticed that something was amiss? What was the first sign of danger?
   - When working with this phase, we help the client to restore lost orienting reflexes.

2. **Active defense**—A lot of activity in the arms and legs —for example, this is the moment when the client was thrashing wildly in the water, trying to keep her head above water, trying to find the bottom with her feet, etc.
   - When working with this phase of the drowning experience, we help the client complete the active defense responses.

3. **The dilemma "to breathe or not to breathe" begins to appear.** At this point in the drowning experience, the client, although still struggling actively, begins to feel the lack of air. As time goes on, the client's attention will be drawn increasingly to this aspect.

4. **Breathing water**—There comes a moment when the client can no longer hold her breath and breathes in water. This moment marks the beginning of a new phase. While phases 2 and 3 are marked by terror and high activity, once the client has begun to breath in water, a certain calm will typically overtake her. This calm, in many cases, is part of an experience that is deeply archetypal and mystical. Physiologically, hypoxia is now setting in, and the brain is starving for oxygen.

   The client's body begins shutting down in the transition toward death. As water flows into the lungs, there is dissociation and freezing, and the brain begins to shut down.

   This is often experienced as a profound moment of surrender, ecstasy, and light. When the person has reached this phase, and is rescued and brought back to life, many times she returns with a sentiment of anger, frustration or longing.

5. **After the event**
   - What kind of help did the client have?
   - Did this help resource the client or further traumatize her?
   - Is there coupling with other similar experiences, such as anesthesia?
   - Was the client teased or reprimanded for almost drowning?

Working with Near Drowning Traumas

- As always, it's a good idea to know what happened afterwards before you start renegotiating the drowning experience itself. Depending on the resource or further traumatization that you encounter here, you may elect not to move to the experiences after the drowning incident until more resources are available.
- When you begin working with a specific trauma, it's a good idea, to begin with the first orientation to danger. In this way, we start with the periphery of the traumatic experience, and the first loop of the trauma vortex. Allowing this layer to discharge before going deeper is always helpful.
- In a drowning trauma, we frequently find active survival responses (trying to keep one's head above water) intertwined with passive survival responses (surrender). To renegotiate the drowning, it will be necessary to complete both types of response.
    - A general rule that holds for all types of trauma is to complete and integrate at least some of the active responses before going into the freeze and death state responses. However, each case is unique. In all cases, you will be following the coupling dynamics, weaving back and forth between over- and undercoupled elements.
- If the client went as far as the 4th stage of drowning—the stage of breathing in water - it is possible that an important part of the renegotiation will involve the conflict between returning to life and "staying in the light".
    - Once the passive "surrender" responses are completed, it becomes more possible for the client to integrate some of the extreme experiences of fear and beauty that she may have had into more normal awareness.
    - Sometimes, the client has had a near death experience, but never quite figured out that she returned. In this case, it can be quite useful to ask the client to repeat the phrase "I'm alive and I'm real", or "I choose life for the second time", as a way of bringing this realization home. This often liberates a significant amount of vitality.
- Stay alert for archetypal themes such as ocean, water, uterus, mother, and any renegotiation that may need to happen at this level.
- Drownings, like many other traumas, can involve elements of shame. Often, the person who almost drowned, far from being a weak swimmer, was someone who swam well and simply misjudged the water, the currents, or even her own body's capacity for endurance.

High Impact/Failure of Physical Defense

Additional sub-categories included

- **Falls**
- **Head Injury**
- **High impact/Motor Vehicle Accidents** *(included in Intermediate Module 2)*

General Overview

This category includes any accident with strong forces (gravity forces, impact, acceleration, deceleration, torsion) where a person abruptly loses equilibrium. The body's normal physical defensive reflexes and mechanisms have been overcome, either by the sheer magnitude of the event, or by the speed at which it took place. The types of events that fit into this category include: falls, high impact accidents, and head injury. If you quickly lose your ability to defend yourself, it fits in this category.

Key Defenses and Coping Mechanisms

The responses and reflexes in this category are almost entirely physical. The coping strategies also tend to be quite physical: avoidance of (or attraction to) challenges to equilibrium, being overly careful in movements, overreacting to acceleration or other movement stimuli, and so forth.

Primary Characteristics and Hallmarks

- There is commonly at least some physical injury involved in this category, so physical treatment and repair is often the first priority.
- This category is one in which the event is experienced very physically; it quite commonly results in the disruption of orienting and physical defensive responses.
- The physiology has been overwhelmed by the magnitude and speed of the event, so multiple body systems may be simultaneously disrupted: equilibrium, reflexes, memory, and the musculo-skeletal system.
- It is common to have large gaps in the mental memory of the event as well as sensory-motor amnesia.

Common Symptoms

(Also see sub-categories below and in Module 2)

- Dizziness, disequilibrium, balance problems, a sense of physical vulnerability (or feeling no vulnerability at all), anxiety about falling, clumsiness (particularly in relation to spatial awareness), physical over-control, vertigo, fear of heights.
- Disruption in self-protection:
    - Almost complete lack of physical defensive impulses – sometimes generalized, sometimes specific to just one type of response or one quadrant of spatial awareness.

- Conversely, defensive impulses may be hyper-responsive, and awareness of the environment may be excessive or obsessive.

- Easily disoriented: mentally, physically, spatially. Gets lost easily, cannot understand verbal instructions of spatial relationships (i.e., confuses left and right), cannot tell how far away/how close objects are.
- Has a distorted sense of the size of her own body and/or its relationship to outside objects.
- Poor eye-hand coordination.
- Blind spots in boundaries.

Working with High Impact/Failure of Physical Defense

(Also see sub-categories below and in Module 2)

- It is essential to work slowly. The focus is to slow down the experience enough for the client to re-orient and understand what happened. It is not necessary to accurately "figure out what happened", but there must be continuity in the body experience of the event.
- It is critical to restore orienting and physical defensive responses. Track micro-movements and intentional movements.
- Work with sensory-motor amnesia, filling in holes step by step.
- The faster and greater the impact, the more stretching of time is needed. Slow time down. It may take hours to completely renegotiate only a few seconds of the accident.
- Stay with sensation and the physiology (rather than the story); slow down even further as the client comes closer to T-0.

Sub-categories of High Impact/Failure of Physical Defense

Falls

- Orienting is one of the most critical elements in working effectively with falls. The client needs to know where the ground is, either by being able to see it or otherwise sense it, before you can proceed through the falling sequence.
- Re-establish defensive responses as fully as possible before proceeding through the falling sequence. Track for the initial, often disorganized, impulses toward self-protection. Keep "rewinding" and slowing down so these disorganized responses have time to fully organize before you proceed into the renegotiation of the fall itself.
- Work with the fall in small increments. Make sure the client is re-oriented in time and space before proceeding to the next increment.
- Because the client may reconnect with the speed of the fall, it is usually best to begin this type of work on the floor.

- Once the renegotiation has taken place, give the client plenty of time to feel their relationship to the earth. Explore it as fully as possible through sensation: how do their feet feel on the ground, where is their weight resting, is it equal on both sides of their body, and so forth.
- Remember that falls from a shorter distance can actually create more injury. (Trauma; An Osteopathic Approach, Jean-Pierre Barral)

Head Injury (Acquired Brain Injury)

Injury to the brain and/or spine is one of the most frightening types of injuries for the body to experience. It is important to understand the high levels of activation associated with it. Appropriate scope of practice needs to be attended to when working with acquired brain injury. If you do not having training and knowledge in working with head injuries, you should not be working with an acute head injury. At most, standard SE first aid can be applied. However, an acute head injury will mean that the client's brain and nervous system are responding in perhaps eccentric ways, and it is sometimes difficult to manage a session adequately when there is serious brain dysfunction.

With a brain injury that has had sufficient recovery time (6 months to 2 years, depending on the severity), then there is less concern in using standard SE methods for resolving the traumatic stress associated with the injury process. However, the client's eccentric brain function may still pose a challenge for you in understanding their responses to your interventions. Symptoms of brain injury can mimic PTSD and vice versa, so they can be challenging to work with.

Common Symptoms – Head Injury/Acquired Brain Injury

- Acquired Brain Injury symptoms are divided into four categories:
    - Cognitive
    - Perceptive
    - Physical
    - Emotional and Behavioral

Primary Characteristics and Hallmarks–Head Injury

- Acquired brain injury can accompany high impact traumas, such as falls, car accidents, etc.
- Acquired brain injury can occur even when there has been no coma, and the cranium has not been pierced or broken, due to the brain impacting against the inside of the cranium and/or brain tissue shearing from the force of acceleration within the cranium.
- Acquired brain injury can happen when there has been impact to any part of the cranial sacral system—thus, a person who falls and hits her tailbone can also be a candidate for acquired brain injury.
- There is little knowledge in the general public about brain injury. It's relatively common for someone to suffer mild brain injury from an accident, and not recognize the symptoms as those of brain injury. Men typically under-report symptoms of brain injury.
- The symptoms of brain injury can mimic those of trauma. As is the case for clients, it is also possible for trauma therapists to misunderstand the brain injury symptoms, and assume they are merely symptoms of trauma.

- Very common symptoms include:
    - Disorientation
    - Cognitive dysfunction
    - Failure of short term memory
    - Emotional volatility, lability or dulling
    - Flooding of past traumas
    - Enormous difficulty functioning in the tiny details of day to day life
- The symptoms of acquired brain injury can take a long time to normalize. The average recovery time for closed-head injuries is two years. Some changes in brain function may be permanent.
- If you have a client who has suffered a neck, spine or head injury, even a relatively minor one, it's important that he or she be assessed for head injury. There is increasing awareness in the medical community of the accumulated effects of repeated mild brain injury, so requesting an assessment has become more productive.

Working with Acquired Brain Injury

- Work with the incident and the activation from the incident. Working with SE shortly following an incident can prevent or palliate the symptoms of acquired brain injury. Again, you must stay within your appropriate scope of practice when working immediately after a brain injury.
- Most typically, you will need to help educate your client about what is normal in their recovery after a brain injury. If this will be an area of focus in your practice, it is important to educate yourself about the standard benchmarks of recovery, the common symptoms, and the common challenges for those with brain injuries (resources are listed at the end of this section).
- There are support groups for people with acquired brain injuries. It can be very resourcing to be with other people who are going through similar experiences, and to share strategies for coping.
- Get to know some good referrals for cognitive therapists and speech pathologists in your area to whom you can refer clients with acquired brain injury.
- Shortly after an accident, it is not uncommon for the client to become quite unstable emotionally and be flooded with issues from past traumas—perhaps even traumas that have already been resolved. It is important for the therapist not to be seduced into working with these older or deeper issues that emerge at this time. The first priority is to help the client stabilize and return to a functional level in life.

Additional Resources and References

Sites for more information on Acquired Brain Injury

www.tbi.org Acquired Brain Injuries Group—this site has a number of excellent articles. Their Frequently Asked Questions on Acquired Brain Injury is an excellent short article to give to clients who need to know more.

www.biausa.org United States Brain Injury Association

Coping with Mild Traumatic Brain Injury, by Diane Roberts Stoler and Barbara Albers Hill.

Inescapable Attack

Additional Sub-Categories include:

- **Animal Attack**
- **Escape Inhibited**
- **Rape/Sexual Abuse** ***(included in Intermediate Module 2)***

General Overview

This category includes attack by a perceived predator, especially when the escape is inhibited by physical restraint, internally generated conflict, and/or real or perceived lack of response. Any sources in which escape is inhibited, such as medical procedures when restrained, witnessing violence to another, being trapped in a vehicle after an accident, animal attacks,, rape.

Primary Characteristics and Hallmarks

- High arousal and thwarted or extinguished defensive impulses; hypervigilance with exaggerated defense.
- Specific freezing; situational or generalized (e.g.., afraid of all men); immobility and hypervigilance; helplessness; boundary and empowerment difficulties; reenactment; dream disturbance.
- Delayed reactions are the rule.
- Overlaps with developmental stages ofdefensive reflexes. That is, if there is developmental disturbance of defensive reflexes, this can potentiate responses within this category of trauma.

Key Defensive Impulses

- Generally primitive in nature, and physical: urge to bite, kick, scratch, scream, run.
- There is often a survival dilemma between the need to fight, and the possibly greater potential for survival by submitting. Apparently mutually exclusive survival impulses are at odds with each other.

Common Symptoms

- Excessive fear; feelings that the world is a dangerous place; anxiety.
- Sensitivities to sounds, light; difficulty sleeping.
- Difficulty in defending oneself.
- Stuck in a pattern of compulsive attack; uncontrollable outbursts of rage. Sometimes compulsive need to place oneself in danger (to prove one can take care of oneself).
- Stuck in pattern of running away (difficulty with commitment).
- Stuck in a pattern of helplessness.
- Healthy aggression gets repressed or frozen.
- Frequent re-enactments.

Working with Inescapable Attack

- Help client restore defensive and orienting impulses, and complete defensive responses.
- Will often need to work with the dilemma of contrary defensive urges (fight or submit).
- Sometimes the factor that prevented the client from escaping was a non-physical restriction.
- An example is an animal who attacked previously, and is still nearby, such that movement may re-trigger attack.
- In this case, there is a conscious, volitional decision to resist the more spontaneous and instinctual response to escape. This creates significant conflict in the nervous system.
- It is important to work back and forth between the inhibition/freezing and the more active responses of fight and flight, helping the former to unfreeze, and encouraging the latter to surface and complete.
- When the client's active defensive response was overcome, the physiology may have deleted, or extinguished, that defensive response from his/her potential repertoire. By uncoupling fear or rage from impotence or immobility, the active defensive impulse is likely to be restored. Work with helplessness and defeat primarily by resourcing and reinstating active responses.
- Validate the efforts toward survival: "You did what you could." Work with the shame by building resources and working with the physiology of shame; acknowledge the freeze response, and that the client had no other choice; acknowledge that what they did worked because it helped them survive.
- Defensive urges in this category are often quite primitive, and focus on annihilation of the "opponent" (even when it is something inanimate). The strength and intensity of these urges may frighten the client. Work in small titrations so the client can explore the physicality of the urges to attack and defend, without feeling the need to act overtly on these urges.
- Attack and defense urges may show strongly in facial expression (lips drawn back from clenched teeth, intense staring, urge to make animal-like sounds). Again, support the client in noticing and completing these responses, without having to make cognitive interpretations about them.
- Defensive responses will typically be quite physical in nature, and center on the face (including the voice), arms, and legs.

Sub-Categories of Inescapable Attack

Animal Attack

- In this category of trauma, you will often spend a lot of time with the orienting phase of the threat response cycle during the renegotiation phase. Often, the perception of the first indicators of danger provide the greatest potential to help restore active survival responses.
- Survival responses will often be primitive and basic: shouting, threatening, playing dead, scratching, biting.
- Work will often need to be done with issues related to the behavior of others who did not help; most frequently, the owners of attacking animals, who did nothing to control their animal, or who allowed the animal to be off-leash or otherwise unrestrained.
- If the attack was severe, almost invariably there will be a freeze state that must be renegotiated.
- In animal attack, there is often a secondary concern about rabies, particularly if the animal was not captured. The client's fears about possible infection, or treatment, may need to be addressed as part of your work in this category.

Escape Inhibited

- The most common source of this category is a motor vehicle accident in which the person is trapped in the vehicle.
- An isometric/isotonic movement is often helpful when the client's defensive responses are beginning to organize. Have the client push against resistance (against a pillow you hold at their hands or feet, for example). Slowly allow the pushing to overcome your resistance. and allow the limbs to move to their full range of movement. This must be done slowly, and only when the client is able to adequately manage their activation. These movements help all the muscles engage in an organized way, as the completion of movement takes place.

  Caution: This exercise should not be done if the client's escape was inhibited by a person rather than an inanimate object; there is too much risk of reenactment, or of placing yourself in the role of the perpetrator.
- The behavior of others at the scene is often a key issue that needs to be dealt with in this category:
  - Rescue personnel who did not adequately inform the victim of attempts that were being made to free him/her.
  - Being alone during the incident, with no one to help with escape.
  - Others present at the scene who contributed to restraint.
  - Others at the scene who did nothing to aid in escape.

  Sometimes the victim has misinterpreted the behaviors of others (such as assuming no one was helping, when in fact those at the scene were trying to ensure greater safety by first securing the scene adequately), and this needs to be sorted through in the renegotiation process.

Student Self-Assessment Questionnaire
Intermediate: 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 idea that different categories of trauma produce differences in physiology, defensive impulses and coping strategies	1	2	3	4	5
The importance of ongoing self-regulation when working with challenging trauma material	1	2	3	4	5
Understanding that different categories can interact with each other	1	2	3	4	5
Global High Intensity Activation					
The primary characteristics and hallmarks of this category	1	2	3	4	5
The key defensive impulses and typical coping mechanisms of this category	1	2	3	4	5
The common symptoms of this category	1	2	3	4	5
The basic method of working with GHIA	1	2	3	4	5
That there are sub-categories that have slightly different characteristics	1	2	3	4	5
The basics of working with pre- and peri-natal trauma	1	2	3	4	5
The basics of working with anesthesia that is coupled with GHIA	1	2	3	4	5
The basics of working with high fevers coupled with GHIA	1	2	3	4	5
The basics of working with suffocation, choking, drowning	1	2	3	4	5

Part 1 continues on next page

Part 1, continued

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
High Impact/Failure of Physical Defense					
The primary characteristics and hallmarks of this category	1	2	3	4	5
The key defenses and coping mechanisms of this category	1	2	3	4	5
The common symptoms of this category	1	2	3	4	5
The basics of how to work with high impact/ failure of physical defense	1	2	3	4	5
That there are sub-categories that have slightly different characteristics	1	2	3	4	5
The basics of working with falls	1	2	3	4	5
The basics of working with head injury	1	2	3	4	5
Inescapable Attack					
The primary characteristics and hallmarks of this category	1	2	3	4	5
The key defenses and coping mechanisms of this category	1	2	3	4	5
The common symptoms of this category	1	2	3	4	5
The basics of how to work with inescapable attack	1	2	3	4	5
That there are sub-categories that have slightly different characteristics	1	2	3	4	5
The basics of working with inhibited escape	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
Have a beginning ability to recognize indicators for each category in the module:	1	2	3	4	5
GHIA	1	2	3	4	5
High Impact/Failure of Physical Defense	1	2	3	4	5
Inescapable Attack	1	2	3	4	5
Have a beginning ability to make appropriate interventions for each category in the module	1	2	3	4	5
Can work with small enough titrations and pendulations to manage the activation of GHIA	1	2	3	4	5
Ability to support completion of incomplete responses for GHIA:	1	2	3	4	5
General	1	2	3	4	5
Pre- and peri-natal	1	2	3	4	5
Anesthesia	1	2	3	4	5
High fever	1	2	3	4	5
Suffocation, choking, drowning	1	2	3	4	5
Ability to support completion of incomplete responses for High Impact/Failure of Physical Defense	1	2	3	4	5
Falls	1	2	3	4	5
Head Injury	1	2	3	4	5
Ability to support completion of incomplete responses for Inescapable Attack	1	2	3	4	5
Inhibited escape	1	2	3	4	5
Other _____	1	2	3	4	5

Part 3

Based on your responses above, on what areas would you like to focus during consultations? (These, of course, do not have to be the only areas on which you will work in consultations.)

_____

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