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INTERMEDIATE YEAR

Module 2

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CONTENTS

3 HIGH IMPACT/FAILURE OF PHYSICAL DEFENSE

8 INESCAPABLE ATTACK

11 PHYSICAL INJURY

20 STUDENT SELF-ASSESSMENT QUESTIONNAIRE

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HIGH IMPACT/FAILURE OF PHYSICAL DEFENSE

(Continued from Module 1)

High Impact/Failure of Physical Defense

(Continued from Module 1)

High Impact and Motor Vehicle Accidents (MVA)

General Overview

High impact accidents are exactly that—accidents in which a client is traumatized by falling, being thrown from a moving vehicle or colliding with something. Automobile accidents are extremely common in this category, and in this section we will focus primarily on them. However, the different elements of treatment for car accidents are easily applied to other kinds of high impact traumas—skiing accidents, bicycle accidents, and so forth.

Frequently, our clients do not consider car accidents as traumas. "I wasn't hurt, I was fine." When SE therapists hear these phrases, it's important for them to realize that even in car accidents where clients were not physically injured, there might still be considerable traumatization.

Primary Characteristics and Hallmarks

- A car accident happens in a short, compacted, very fast
  interval of time.
- There is often an element of surprise.
- The accident is often accompanied by a loud and frightening sound.
- The client faces a life threatening situation at a time when they are:
  - Enclosed
  - Immobilized by a seatbelt (we hope)
    This is the perfect set-up to create a freeze response.

According to a paper, "Victims of Traffic Accidents: Incidence and Prevention of Post-Traumatic Stress Disorder," (Brom, Kleber and Hofman) accident victims tend to compulsively re-experience parts of the accident or the whole event. They have a tendency not to remember what has happened, be unwilling to discuss the event, or feel emotionally numb. They experience feelings of guilt, depression, behavior changes, feelings of anger and anxiety, and sleeping disturbances that can last for months or even years."

—Crash Course,
Diane Poole Heller, page 3

- In terms of the client's orientation to gravity and systems of postural tonus, we observe several things:
  - There is a flood of different vestibular stimuli—acceleration, deceleration, and sudden changes in the body's relationship to gravity (for example, when the car capsizes or rolls).
  - Stretch receptors (muscle receptors that tell our brain stem when to contract a muscle to maintain us upright or to keep the muscle from tearing) throughout the client's body are abruptly activated—with no preparation or warning—and set off a flood of information to the brain stem, creating a state of global alert. In terms of preparatory tonus and movement, the client's body has barely braced itself for the shock of impact when it is already needing to brace for the countershock, or any other sudden movements that may be forthcoming after the impact.

Working with High Impact Injuries and MVA

- Again, you must stay within your scope of practice if you are working with a recent accident from which the client is still experiencing acute injury.
- If physical injury remains that limits the client's movement, you may not be able to completely restore the orienting and defensive movements until after the client has made further recovery.
- If the client is still physically recovering from the accident, you'll need to titrate the amount of trauma-related work you do with them. Although working with the trauma of their accident will be very helpful, it can sometimes be energy consuming. If their tissue repair slows down, you may be working too deeply, and essentially siphoning their limited physical resources into trauma renegotiation work. Now is not the time to try to renegotiate all their deepest traumas. Instead, your focus should be on freeing up the body's resources for the healing process. (See the Physical Injury category,
page I2.10, for further information.)
- Since a car accident almost always involves a flooding of compressed information in a short interval of time, one of the most important elements in treating a car accident is to take things very slowly. The therapist needs to learn how to stretch out time. Sometimes you may need to take hours to work with what happened in a fraction of a second.
- Slowly, slowly, slowly, slowly. The client's tendency will always be to accelerate, because everything happened so quickly. The therapist's job is to keep the client at a speed where he can digest the information that has been held in his nervous system since the event. It is very important for the therapist to remember that the speed at which the client is allowed to proceed will make the difference between reenactment and renegotiation.
- Before working with the details, help the client to discharge the general activation. As with other traumas, we work first with what came before the accident and what came after the accident, and then, little by little, as the overall activation lessens, we move more towards the core of the event.
- When there is constriction and diminished movement in the client's neck, work to restore orienting reflexes, and expand any constricted images pertaining to the accident. In doing so, remember that "images" in the SIBAM model include images from all of the sensory channels—visual, auditory,

tactile, olfactory and gustatory.

- Coupling dynamics
  - We see overcoupling in the speed at which the accident happened, and the way the client will tend to speed things up in the session.
  - We see undercoupling in the confusion, vertigo, and the places where the client has no clear memory of what happened. It is quite common for the client to have dissociated during the experience.
- Sequencing is important. In auto accidents, it is as if somebody took a jigsaw puzzle, threw it into the air, and the pieces came down on the ground every which way. In the beginning, the client might not have much of an idea what happened when, which way his body was thrown in the accident, etc. As we work with the experience, and the orienting and defensive responses complete, the activation discharges. Then the pieces of the puzzle will begin to fit together again, and the client will have a better sense of how things happened.
- When the client experiences nausea, vertigo, and disorientation (sensations that frequently accompany car accidents, especially if there was impact to the head), the best way to renegotiate this is to help the client stay with the sensations until they discharge, and the client pendulates into the counter vortex. This can be quite uncomfortable, and the therapist may need to give the client a lot of support to help him gain the confidence to stay with the sensations until they transform.
  - If the sensations of vertigo and spinning become too intense at any time, a very efficient way to help the client pendulate is to first find out which way the dizziness spins, and then have him use his finger to demonstrate a spin in the opposite direction.

Stages of a Car Accident Trauma; Working with Each Stage

(Thanks to Raja Selvam for differentiating and naming these stages)

1. Orientation to danger—What was the first sign the client had that something was wrong?
   Here we help the client to:
   a. Complete incomplete orienting reflexes;
   b. Expand constricted images;
   c. Titrate the state of alarm.
2. Trying to avoid the accident—active responses. For the driver, arms, hands on the steering wheel, foot on the brake. Attempts to protect oneself, etc. Work here to complete the active responses of fight and flight.
3. Preparation for impact—Generally, this phase involves tensing and bracing the body. If the client dissociated, this is frequently the moment when he did so. In this phase, work with the following elements:
   a. Completing defensive responses.
   b. Completing the brace-collapse-rebound sequence (remember that before this can happen, you need to help the client uncouple fear from the immobility response).

c. If the client dissociated from his body as a way to escape the experience of impact, stay with him as he dissociates, help him notice where he goes, what it's like, and how exactly he feels himself leaving his body. There will come a moment when he naturally returns. The above is true in cases where the dissociation occurs at a slow to moderate pace. If the dissociation occurs in the blink of an eye, it is necessary to titrate first, until the client can feel the dissociation happening, and allow himself to go with it at a pace where he is capable of noticing what happens.

d. It may be that T minus 1 (the increment of time just before impact) is the place associated with the maximum activation.

4. **Impact**—The impact may have been slight, or it may have been at the combined speeds of hundreds of miles per hour. Here, depending on what occurred, you may find enormous constriction, pain, loud strident noises, etc.
5. **Post-Impact**—Before working with car accident trauma, it is important to have an idea of what happened after the impact. What came next may be resourcing, or it may have been even more traumatic than the accident itself. Know what happened here, and plan accordingly.

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INESCAPABLE ATTACK

Inescapable Attack
(Continued from Module 1)

Rape/Sexual Abuse

Working with Rape/Sexual Abuse

- Bring back sexual feeling slowly by staying with sensation, acknowledging, and resourcing.
- As when a person is attacked by an animal, rape may evoke animal responses like biting.
- Will likely need repeated work to restore appropriate boundaries, particularly when they have been repeatedly transgressed via chronic sexual abuse.
- Work with grounding and resourcing through the legs. Help client handle the sexual energy that arises; help to move it through the entire body rather than localizing in genitals.
- Bodywork:
  - Notice overall sensation
  - Notice a clear body boundary at the surface
  - Notice preferences in type of touch; being able to say yes or no to touch (or types/locations of touch).
  - Usually, the pelvis and legs will be the last areas the client can tolerate being touched. May be able to begin with gentle contact to shoulders, neck. Supportive and respectful touch can help to renegotiate feelings of violation and constraint.
- Other categories of trauma can mimic rape or sexual abuse, such as medical procedures in which the client was restrained, particularly if they included gynecological procedures. Practitioners must be careful that they don't assume a rape or sexual abuse experience based on the client's presentation of similar symptoms or body memories.

Once a sense of basic safety has been reestablished, the survivor needs the help of others in rebuilding a positive view of the self. The regulation of intimacy and aggression, disrupted by the trauma, must be restored. This requires that others show some tolerance for the survivor's fluctuating need for closeness and distance, and some respect for her attempts to reestablish autonomy and self-control. It does not require that others tolerate uncontrolled outbursts of aggression; such tolerance is in fact counterproductive, since it ultimately increases the survivor's burden of guilt and shame.

—Trauma and Recovery,
Judith Herman, MD, page 63.

- Shame may not fully resolve until healthy aggression is restored.
- These experiences can be potentiated in the freeze/dissociative states, so that as the client begins to mobilize from these states, high levels of rage, anger, or other strong emotions may also mobilize – even when they have not been present to date.
- Rape and sexual abuse can couple with GHIA.

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PHYSICAL INJURY

Physical Injury

Additional Sub-Categories include:

- Surgery
- Poisoning
- Burns

General Overview

In physical injury, the underlying factor is that the stimulus or threat is inside the body. Since there is no external threat, active defenses can't be used, and the body goes into a mode of passive conservation. In this category, the practitioner must balance the need for trauma resolution with the need for physical recovery. In general, while the active physical healing process is taking place, trauma recovery work will focus on first aid and on supporting the conservation and withdrawal process, and will work in only a limited way with high levels of activation.

The types of potentially traumatic experiences that fall into the Physical Injury category include: surgery, anesthesia, burns, poisoning, hospitalizations, fractures, wounds (stabbing, gunshot, wounds from accidents), and strong allergic reactions.

Key Defensive Impulses and Coping Mechanisms

Because these types of threats are perceived as coming from within the body, active defense is limited, with the exception of the immune system. Particularly when traumatic stress associated with an injury goes unresolved for a long period, the immune system can express the equivalent of constriction or hyper-vigilance; it might become under- or overactive in comparison to its normal immune response. In an attempt to pinpoint the location of the threat and make it more well-defined, clients will often project their internal sense of danger onto the external environment. This will tend to predispose people with

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.

these types of traumas toward environmental sensitivities and anxiety about the external environment. It can also have the unfortunate effect of alienating their human resources and support systems.

Common Symptoms

- When traumatic response is coupled with symptoms of physical injury, these symptoms are often exaggerated, and the client will tend to recover more slowly.
- When traumatic stress is associated with a physical injury, scars from that injury (or surgery) will often look like they haven't healed properly, and may look fresh, red or otherwise not integrated with the rest of the skin, sometimes for many years after the injury. In this case, the physical scar often acts as an indicator of the unhealed traumatic wound.
- Clients will often display symptoms of not integrating the physical experience of their injury into normal awareness (see also Surgeries, page I2.12):
  - General or specific amnesia about what took place.
  - Disorganized and fragmented reports of the experience. It's common for clients to leave out significant aspects of the experience in their descriptions.
  - Unreasonable or unrealistic fears associated with the experience. ("That doctor was trying to kill me.")
  - General malaise, without a specific source.
- Symptoms of under- or overactive immune system:
  - Wounds don't heal within a normal time frame.
  - Skin disorders, chronic inflammation, allergies – signals that the immune system is over-responding to stimuli.
- Generalized fears of the external environment. When active defenses are useless, clients will often experience a sense of danger without knowing the source, and a concurrent inability to defend against that unknown danger.
- Clients can be hypochondriacally obsessed about their physical symptoms; the smallest signal of disturbance is often taken as a major illness; benign body processes can be interpreted as disturbances.

Working with Physical Injury

- The physical integrity of the body has been compromised. Particularly with disorders that are complex and do not have clear treatment outcomes, clients can be extremely frightened by the physical sensations that accompany those disorders. It is important to normalize what the client is feeling, and help them understand how the body responds to injury or other physical insults.
- In the medical environment, health care providers often do not understand how frightening the circumstances are for the patient, and frequently do not provide the most basic information about what is normal for the client to experience, what the client should or should not be alarmed about in terms of symptoms, how long the recovery time will be, and so forth. It is very helpful for the client to

have this type of information. If you do not know what these parameters are for the client's injury or disorder, consult with a medically knowledgeable source to assist the client in gathering the needed information, or help the client generate a list of questions to ask their medical care providers.

- Keep in mind that the client needs body resources for the physical healing process. Trauma renegotiation work should not be done at the expense of physical healing. In the early stages of physical healing, trauma recovery should focus on first aid and support of that healing. Deep trauma renegotiation uses body resources, particularly if high levels of activation are accessed, and can be tiring for the client. If the client's wounds begin to slow in their healing, this is a sign that the trauma work being done is likely going too deep and is siphoning off body resources needed for physical healing.
- Support whatever active defense arises, no matter how small. For example, with airborne poisoning, the client may begin to cough or gag as the renegotiation process takes place. In a titrated way, encourage the client to stay with these normal defensive responses.
- Support congruent defensive impulses. During the trauma renegotiation process, the client will sometimes first attempt an active, yet ineffective or incongruent, defense when defensive impulses first re-emerge. Keep the process slow enough so that you and the client can notice more congruent defenses as they organize.
- Keep in mind that sometimes the only defense is to stay quiet and relaxed so as to limit further injury. You need to ensure that the client's version of “quiet” is not simply a freeze response. You will need to tease apart the freeze response from the more effective, calm and resource-full response that signals the client is at ease in the face of the physical insult.

Sub-Categories Or Physical Injury

Surgery

Not all surgeries produce surgical trauma. As with potential anesthesia trauma, if the client was highly activated just prior to the surgery, or if the surgery is directly subsequent to a traumatic event (such as a car accident), there is a much greater chance that the surgical process will couple with the high activation. Surgical traumas can be complex to renegotiate because they are inherently complex processes: there is potential involvement of the anesthetic in the client's responses; the client is in a chemically-altered state; there may be thwarted (active) defensive impulses; the anesthesia may create a discontinuous state of awareness that confused the client's understanding of what happened; the body has undergone sometimes dramatic changes, but in an altered state of awareness; there may have been severely challenging events prior to the surgery, and severely challenging events may follow the surgery.

Each of the elements of the surgical process may need to be explored to ensure that all aspects of the potentially traumatic event have been included in the renegotiation process.

Factors that may influence whether or not the patient is traumatized during routine medical procedures:

- The way in which the doctor speaks with the patient (sensitivity, presence and compassion, or lack thereof).
- Information—knowing what will be done, how it will be done and why it is being done.
- Waiting for the patient to be ready before beginning the procedure (for example, when drawing blood or administering an injection).
- The amount of control the patient feels that she has over the situation. Often little things that the doctor, nurse, or hospital staff do or don't do make a big difference.

Common Symptoms

- Foggy, drowsiness, spinning, general dissociation, fugue states, wavery body feeling, floating sensations, sense of unreality.

Key Defensive Impulses and Typical Coping Mechanisms

Surgical trauma can include a number of different categories of trauma simultaneously, and the client can exhibit the symptoms, defensive impulses, and coping mechanisms for each of those categories:

- Inescapable attack—Depending on the type of anesthetic used, the pain impulses to the brain may not be blocked. While the attack (the surgery) is happening, the body is in a state of immobility produced by the anesthesia. The patient is unable to run or fight—both of which her instinctual side would like very much to do. In other words, all the elements of the freeze response—high activation and incapacity to complete active defensive responses--are present. Note: A number of studies have shown that post-surgical recovery is faster and involves fewer complications if a local anesthetic is administered at the incision site, rather than only general anesthetic being used. (Trauma Through a Child's Eyes; Maggie Kline , Peter Levine; page 190.)1
- Physical Injury
- Poisoning
- Suffocation/choking—in the days when ether was used (up until the 1960s) the mask sometimes contributed to an experience of suffocation. Currently, a tube is inserted down the patient's throat during surgery, but this can produce a choking response.

Working with Surgical Trauma

- The body can experience surgery as a profound threat. The fact that the client consented to it makes no difference to the physiology. Sometimes a surgery can go very well, but the client might still have traumatic stress symptoms and be confused about how this could happen. Help them understand that they may be having this post-op response simply due to physiological responses to elements of the surgery that are not in their conscious awareness.
- The comments of medical staff when clients are under anesthesia are very important. In the altered anesthesia state, clients can internalize what was said. Assist the client in externalizing those words.
- Reorient to time/space post-op.

- Re-associate from the anesthesia state into normal awareness.
- Restore any thwarted defensive responses. Identify where defensive responses were active: "I wanted to run, to pull off the mask," etc. This helps the client go into surrender to the anesthesia experience; don't turn it into a spiritual or bardo experience.

1. K. Yashpal, J. Katz, and T.J. Coderre. "Effects of Preemptive or Post-Injury Intrathecal Local Anesthesia on Persistent Nociceptive Responses", Anesthesiology (1996).
2. C. Michaloliakou, F. Chung, S. Sharma, "Preoperative Multimodal Analgesia Facilitates Recovery after Ambulatory Laparascopic Cholecystectomy," Anesth. Analg., 1996.
3. S.I. Marshal and F. Chung, "Discharge Criteria and Complications After Ambulatory Surgery," Anesth. Analg. Vol. 88, No. 3:508 (March 1, 1999).

Preparing a Child for Surgery or Other Medical Procedures

(Adapted from "Trauma Through a Child's Eyes", by Maggie Kline and Peter Levine. Used with permission.)

Your presence during the procedure can be helpful if you are not visibly anxious yourself. Medical personnel may not allow parents to be present for all procedures. It is best to work this out in advance if at all possible, so there is no argument in front of the child. Two procedures that can be particularly terrifying to a child are: 1) being strapped down to an examining table, and 2) being put under anesthesia without being properly prepared.

Before the day of surgery:

1. Be sensitive to the child's needs.
2. Prepare the child for what will happen. Tell them the truth without unnecessary details. Some hospitals have programs that allow the child to visit the hospital prior to the surgery, meet the doctors (or see pictures of them), and do some role-playing. Ideally, the child should at least be shown photographs of what the doctors and nurses will look like with surgical masks on.
3. Staff and parents can arrange a time beforehand so the child can meet the surgical staff when they are wearing normal attire.
4. If the hospital does not have a program for child education, you can prepare your child by having them dress up and play "hospital", going through all the steps in advance.
5. Prepare the child for entering, and coming out of, an altered state by telling (or making up together) a fantasy story.
6. Healing from surgical wounds is more rapid when a local anesthetic has been used at the incision site. Make this request in advance of the surgery.

On the day of surgery:

1. Parents and medical personnel should work out a system by which parents can stay as much as possible with the child.
2. A child should **never** be strapped down to an examining table or put under anesthesia in a terrified state.
3. Ideally, parents should be in the post-operative room when their child is waking up. The child should **never** awaken in the recovery room alone.

After the surgery:

1. Rest speeds recovery.
2. If your child is in pain, have him or her describe the pain, and then find a part of the body that is pain-free, or at least less painful.
3. If the child appears fearful, assist him by using storytelling.

Preparing an Adult Client for Surgery

There are a number of things that can be done pre-surgery that will assure that your client has the best possible chance of coming through with minimal traumatization:

- Educate the client about what will happen (or have the client educate him/herself); determine if they will need an advocate or helper at the hospital; educate about what is needed after the surgery (home help, rest time, help with mobility).
- Support the client to be assertive, so that she is able to ask the doctor all the questions she needs to make an informed decision.
- Identify resources for the O.R. (music, security blanket/item) – it's best to clear this with the hospital staff in advance to ensure that any items can be taken into the O.R. to avoid the client having these items confiscated at the last minute.
- Help the client identify instructions they wish to give surgeon, anesthetist or O.R. staff prior to surgery (asking for reassurances as they go under anesthesia, having the surgeon give news of successful surgery immediately, etc.).
- Visit the hospital and recovery room prior to surgery. Minimize surprises.
- Help the client become accustomed to going in and out of altered states of consciousness. Have client practice letting go into the anesthesia without activation.
- If there is time, renegotiate other surgeries that the client has had. However, if the upcoming surgery is an emergency or is set up for the near future, it is better not to start anything that there isn't time to finish. In this case, concentrate your work on resourcing the client.
- Requests for the surgery itself.
  - Preemptive anesthesia. Preemptive anesthesia means that in addition to the general anesthesia, the patient is given a local anesthetic at the site of the incision. This has been shown to greatly diminish post-operative pain.
  - Request that any talking in the operating room be reduced to the necessary and the neutral—thus reducing the possibility of complications from the fact that the patient's unconscious is highly open and suggestible at that time.
  - If at all possible, arrange for the patient to be accompanied by someone that she loves and trusts—someone who can help her to stay calm.
    - At the time that she goes under the effects of the anesthesia.
    - In the recovery room (the time when the patient first wakes up). If the patient has a friend who is a doctor or a nurse this is best—it may even be possible for the friend to be present in the operating room. Some clients have taken advantage of this supportive presence and the highly suggestible quality of the anesthetized state to come up with a list of positive suggestions, and have their friend read them aloud during the surgery.
- In the recovery room, when the patient is emerging from the effects of the anesthesia, she may tremble, sometimes with considerable intensity. This, as anyone who has studied SE knows, is

one of the very best things that can happen, as it allows for the discharge of the activation from the surgery. Some education about this before the surgery can create the space for this naturally healing response of the body to occur in peace, without medication being given that serves to interrupt this process.

- Pay attention to helping the patient feel as calm and confident as possible as she goes into the anesthetized state, and as she comes out.
- Pre-schedule an appointment with your client for after the surgery. That way the client will know there is immediate help for any lingering after-effects.

Poisoning

If poisoning is acute, first aid measures must first be taken (call poison control center, get to hospital, etc.). With poisoning, the body has been in a very severe survival dilemma: the urge to defend is present, but active defense (such as running) may actually increase the effect of the poisoning. This category often has strong over- and undercoupling simultaneously, which means that the freeze state is also a common default response.

Common Symptoms

- There may be specific aftereffects of the particular poison to which the person was exposed. It is helpful to have information about what the common side effects of that particular poison are, so you have a sense of what damage may have happened to the physiology and tissues, and what responses may need to complete as part of the renegotiation process.
- More generalized symptoms such as chemical sensitivities, weakened immune system, chronic diarrhea, frequent urination, persistent coughing, easily provoked vomiting. Feeling of illness, toxicity. People will often do a lot of fasting and cleansing regimes in an attempt to resolve the feeling of toxicity.
- Clients may have a vague sense of danger, a vague sense of buzzing or activation throughout the body, or experience difficulty sleeping due to feeling an increase of this buzzing/activation as they drop into the sleep state.

Working with Poisoning

- Work with active responses: distaste, aversion, sweating, desire to vomit, spit, cough, urinate or defecate.
- Long term – visceral bodywork is key.
- Poisoning usually produces a strong altered state. Track physiology and give feedback ("You're doing fine."). Get at least a small amount of verbal participation so they don't get lost – not too much or they will come out of that state. As with anesthesia, you want to re-associate from the altered state back to a normal state of awareness.

- Using titration and pendulation, slowly work toward engaging the specific system that was most strongly affected by the poisoning: lungs, nervous system, liver, circulatory system, etc.

Burns

With an acute burn, the first order of business is first aid. As with poisoning, the person can't run from the threat, although you may have to work with a thwarted or unsuccessful attempt to escape prior to being burned, or from the subsequent burn treatment. Burns are extremely painful as they happen, and continue to be painful for a long time afterward. The medical treatment for severe burns is also extremely painful. The activation related to these strong pain sensations gets coupled with the pain itself, so there may be chronic pain patterns or hypersensitivity, both locally in the burn area, or more generalized throughout the body after a severe burn. As the burn heals, it itches, so the intense sensations continue even as healing is taking place.

Working with Burns

- Must process through the strong sensations, until neutral or pleasurable sensations start to predominate and become stable.
- Work with the impulses toward scratching, or rubbing, in micro-movement increments.
- Work with intentional movements, even down to the level of the skin contraction that occurs as the burn takes place.

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