Treating Trauma Master Series

How to Work with the Limbic System to Reverse the Physiological Imprint of Trauma

a TalkBack Session with

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Treating Trauma Master Series: TalkBack #5

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How to Work with the Limbic System to Reverse the Physiological Imprint of Trauma

How Trauma Disconnects the Mind, Brain, and Body

Dr. Buczynski: This is the part where we're going to synthesize all the ideas from Session 5. I'm joined by Dr. Ruth Lanius and Dr. Ron Siegel.

And wasn't that a great session? What stood out to you? What were the biggest takeaways for you?

"When people are traumatized, their traumatic experience is often not accessible to words; they often don't have words for their experience."

Dr. Lanius: The first takeaway for me was that when people are traumatized, their traumatic experience is often not accessible to words; they often don't have words for their experience. That can keep them very isolated, because they can't tell anybody about their traumatic experience.

What's absolutely critical to remember – and I think that really came out in the session today – is that not just *words* are able to tell the story; *the body* tells the story.

And as therapists, that really teaches us that we have to track mind, brain and body.

We've heard a lot during this series that trauma can very much affect body posture – for example, how somebody is sitting, where they're looking.

Whenever we take a trauma history, it's so important not just to pay attention to the words but also to the body.

"Shame responses manifest themselves in the body."

Shame responses, especially, – they're so common in trauma – manifest themselves in the body. When somebody's ashamed, often they look down, their eye gaze is averted.

These different postures and ways that people can or can't make eye contact can be *incredible* knowledge for how a person is feeling.

That was one of the major takeaways for me.

> "No trauma therapy is complete without really addressing brain, mind, and body, and really ***connecting*** all three."

The big theme throughout the series has been that no trauma therapy is complete without really addressing brain, mind, and body, and really *connecting* all three.

As we know, trauma disconnects mind, brain, and body. We know that when people are traumatized, their emotions become useless: they can't fight back, they can't run away – they're trapped in the trauma. If they were to fight back, or if they were to run away, often that would increase their chance of being hurt.

The only way people can deal with that is really disconnect from their emotions, disconnect from their bodies, disconnect from those gut feelings that are so critical in driving what we do.

So what we really need to do in trauma therapy is to *reconnect* mind, brain and body.

That's a *really* important takeaway session from this series.

Dr. Siegel: I was also struck by the themes that were organized around this week – how trauma gets lodged in the body, and all of the different ways we have to access that. Sometimes it's about completing a kind of frozen action; sometimes it's through yoga, or qigong, or other body awareness and freedom technique.

But there's one small point that I wanted to focus on because it was a little issue that came up a few times this week, and it has to do with catharsis.

Why Catharsis Does Not Usually Help Clients Resolve and Integrate Feelings After Trauma

Dr. Siegel: Catharsis was very central in a lot of forms of psychotherapy when people were hitting pillows with tennis rackets and younger therapists may not be aware of this – there were a lot of schools of therapy that were quite widespread, that were all about *how can we get people to express their most raw and their most vivid emotions?* And usually, through some kind of physical expression of this.

But Pat Ogden made a *really* interesting point – she made it just in passing but I've been thinking about it. What was missing in this approach was *mindfulness*.

I remember being at a residential treatment facility (as staff, not a patient – although it could have gone either way!) in the 1970s, where we were doing a *lot* of these cathartic exercises.

The senior mentor there was a wiser, older European-trained psychotherapist. And I asked her, "Is catharsis necessary for people to resolve and integrate feelings?"

And she said, "No, I don't think so. I think what's necessary is being able to *feel* them."

Interestingly, subsequent to that conversation with her, I'd gone off on my first two-week silent meditation retreat.

During a silent meditation retreat, there's this experience that happens which is that all sorts of intense feelings arise in the heart and in the mind, but there is *zero* catharsis; there isn't even *talking,* no less hitting pillows or wailing or that kind of thing.

I had this experience where the feelings would arise, and I'd feel them, and they would seem to integrate without any catharsis at all.

Then there's the later clinical observation – when people *do* move towards catharsis, they don't fully *feel* their feelings. You see this most clearly with anger, when somebody gets angry and they *immediately* discharge it into action or yelling. They don't really *feel* it in the way that a person feels it when they think before they act, stay with the anger, and notice, *Okay, this is anger – what's* this *about?*

"What's important is ***connecting*** to the feeling, rather than necessarily ***expressing*** it ***cathartically***."

It's an important part of when we think about resolving trauma. As Ruth L. was just saying, integration is such a central focus of what we're doing, and catharsis may or may not be the path to that. What's important is *connecting* to the feeling, rather than necessarily *expressing* it *cathartically*.

Dr. Buczynski: Ron, I want to suggest that even *sometimes* with catharsis people are distracting themselves; they're discharging. And in the discharge, that's a satisfying energy but it doesn't necessarily complete in any integrative way.

It's a distraction. It *can* be a distraction – I won't say it always is.

Dr. Siegel: Right. And, again, you see this with anger. Anger often has hurt or fear or sadness underneath it, but if you're into discharging it, as you were just saying, you might not notice those other components.

Dr. Buczynski: In the past, because I've led conferences and there have been a lot of speakers, people will come to me and say, "Oh, that was a powerful session. People really *lost* it in there" – meaning there was a lot of crying.

And I'd always think, *I wonder if we should be measuring the value, or the depth, or the meaning that's acquired by how much people cried.*

And it's the same with by how much people *talked* about – whatever awful event happened, I've seen patients who run that tape, and that's another form of discharge, and not a deep-feeling integration, not a completion.

Dr. Buczynski: Ruth, let's stay a little bit with this idea. Throughout the series we've talked about the positives and negatives of *does the patient have to go into the details of what the trauma specifics were – what occurred during the trauma?*

I'm not talking about people who perhaps can't remember trauma; I'm talking about people who can remember well – but do they need to describe it to us (or in the group, if we're doing group therapy, and so forth)?

I'd like to get your thoughts on, in what situations do you think it's actually helpful for people to go into the story about what happened with the trauma? What instances would you say it's *not* useful to go into the story of what happened in the trauma?

How to Assess Whether Telling Their Trauma Story Will Be Helpful or Harmful for Clients

Dr. Lanius: That's a critical question for all trauma therapists – and actually non-trauma therapists as well.

Traumas are often kept secret. If we discourage people from talking about their trauma, we can actually reenact keeping the trauma secret.

Sometimes when people talk about their trauma histories, it's for the first time – and it's the first time that they've shared the secret, so it's no longer a secret. This, in a way, can be *incredibly* important.

> "Our patients often have not had a chance to speak their truth. They've had to distort their truth in order to survive."

Related to this, our patients often have not had a chance to speak their truth. They've had to distort their truth in order to survive. So, telling the trauma story can also be really helpful in helping somebody speak their truth for the first time and really help them to shift into leading a life where they *can* speak their truth and have a voice.

Talking about the trauma and expressing it in detail – especially later on in therapy when people now *have* words for their trauma – is incredibly important to help people start making meaning of their traumatic experience, and think about how it's affected their life, how it's affected the losses they've had.

> "Words are very important to articulate what a future would look like."

It really helps the grieving process, and it really helps them to articulate the future – which often is not present in our traumatized clients either: they don't have a future.

So, words are very important to begin to articulate what a future would look like as well.

Now, when do I think it's harmful to talk about or not beneficial to talk about the trauma directly?

If somebody can't stay within that window of tolerance that we've talked so much about during this series – if they get pushed outside the window of tolerance while talking about their trauma – I don't think it's beneficial.

It's easy to obverse symptoms of hyperarousal, because people get so upset, anxious, angry or whatever, or ashamed where they look down – but it's more difficult when they become hypoaroused and when they numb out.

> "It's easy to obverse symptoms of hyperarousal but it's more difficult when they become hypoaroused and when they numb out."

As therapists, we have to be very keen on observing that. We have to check in with our clients often – you know, "Are you numbing out? Are you still able to feel something when you're talking about the trauma, or have you shut off completely?"

Sometimes a cue is when they go into this intellectualized conversation about the trauma – you know, "I did this, and then I got raped, and then this happened, and that happened . . . " and you lose any emotion.

It's *really* important to check in about that.

How to Establish Safety for Someone Who Has Experienced Childhood Trauma

Dr. Buczynski: Ron; Bessel van der Kolk talked about how kids sometimes cope with trauma by shutting down. What are some of the long-term implications where a child shuts down in response to trauma?

Dr. Siegel: Bessel actually talked about two sides of it. He talked about the shutting down, and the long-term consequence of that – the kid misses out on development.

I've had traumatized patients tell me that there were whole years in school where they learned nothing and had no connection to other kids because they were shut down.

Bessel also talked, interestingly, about the kids who can't sit still in class because of their trauma. I had a lot – I spent 25 years in a child community mental health system working as chief psychologist.

We observed over time that there were kind of two sorts of ADHD, Attention Deficit Hyperactivity Disorder.

In one set, it would be, this child – often a boy – was the middle child in a well-functioning family, and neither of his older or younger siblings had trouble paying attention; he was cuddly and connected and spontaneous and fun, but he wouldn't focus on his math. That was the kind of neurologically-driven ADHD, if you will.

Then there were the other kids, from families that were chaotic and often had drug abuse, or incarceration, or serious problems in the family; all of the siblings were badly dysregulated, and these kids couldn't sit still very well. The traumas in the family had created problematic attachment histories and had made them really feel not safe all the time, and they would vacillate between being hypo- and hyperaroused.

It's interesting diagnostically to try to figure this out when we're working with kids –particularly in school settings – to figure out, "Well, which flavor is it?"

When it's the "straight neurological flavor," stimulating meds and coping strategies make perfect sense. But oftentimes it's this other trauma which is causing the kid to act ADD or shut down – and there, there's much more difficult work.

First, try to establish a safe environment in the family so that the child isn't being retraumatized. That itself

obviously can be an enormous project because the parents are traumatized themselves and dysregulated. And, once having done that, create some avenue for the child to integrate all the split-off feelings that are difficult to tolerate.

"There are so many *small-t traumas* that are pressing for expression in our hearts and minds—they make it hard to focus."

It's not just children this way; all of us have restlessness or difficulty. You see this when people try to meditate, and they say, "Oh, gosh, it's so hard for me to focus. It's so hard for me to sit still."

A big part of that is that there are so many *small-t traumas* – feelings, memories, events – that are pressing for expression in our hearts and minds, and they make it hard to focus. So, it's not just kids.

Strategies to Help Clients "Unlearn" Their Body's Response to Trauma

Dr. Buczynski: Tonight we looked at yoga as one way to change the patterns that the body learns in response to trauma. What are some other ways that we might do this?

Dr. Lanius: Bessel has talked about it in the past – the use of karate or self-defense training.

As we've talked about throughout this series, our patients cannot activate active defensive responses. They're passive and incredibly frightened to engage in these active defensive responses. Because in the past, that often led to increased violence or increased chances of getting hurt.

So, it's really teaching them to have a sense in their body that they keep themselves safe. Self-defense can be absolutely critical, and can really start to bring some positive emotion online as well.

Sometimes people are too terrified to engage in this kind of training – but as soon as my patients feel that they're ready to do so, I always encourage some kind of self-defense training.

Especially in people who have a lot of out-of-body experiences and depersonalization responses – who are really disconnected from their own bodies, who have trouble feeling, who are just really, really detached – will tell me, "You know, I'm rarely in my body."

I work with them to find some activities that really cannot be done by being out of your body – for example, horseback riding or rock climbing.

I find that horses, of course, are a great attachment resource for a lot of people. But once people start riding a horse, they also have to be in their body, which is really hard for our traumatized clients.

Learning how to ride and learning how to be in your body – especially when you're working with a horse that's also an attachment resource – can be incredibly *helpful*.

I also have a police detective who has chronic symptoms of depersonalization, and what he finds most helpful is rock climbing. Again, if you're rock climbing, you can't be out of your body because you'd fall down. And he finds it helpful to go rock climbing; that really helps him to become more aware of his body and to be more in his body.

Dr. Siegel: I really like the examples that you just gave there, Ruth L.

I would add, in a similar vein, I don't know how or if these exist everywhere in the US and in Canada or if they've made it into Europe, but – there are these *model mugging* programs in which people are taught basic self-defense moves.

It's often a police officer or counselor or somebody who's teaching this, and they look like the Michelin Tire Man; they're covered in foam. And people learn how to defend themselves in this way and it's very physical – along the lines of the things, Ruth, that you were just discussing.

I've seen people feel enormously more connected and empowered from feeling like, "Hey, I can do something here now."

The other whole set of approaches – which I think are in some ways more risky, so we have to be much more careful about keeping people within the window of tolerance – are the various what we might call the *Reichian approaches.* All, based on Wilhelm Reich's work before he moved into the orgone boxes and things that were a little more supernatural-based. He talked a lot about character armor.

"When we've experienced hurts that we haven't been able to fully integrate, there are many ways to work with ***connecting*** to it first and then ***releasing*** it."

When we've experienced hurts that we haven't been able to fully integrate, it's lodged in the musculature in tension in various ways, and there are many ways to work with *connecting* to it first and then *releasing* it.

There's bioenergetics, that was developed by Al Lowen – which I happen to have a personal connection; Al

Lowen happened to be my father's first cousin so I could tell you stories about "Uncle Al" at some point.

Nonetheless, he developed an interesting Reichian therapy that way. **Rolfing**, that Ida Rolf came up with, is a way of addressing it through actually doing deep-muscle massage.

Again, these things have the potential to take people out of their window of tolerance because they can be very liberating of a lot of feeling, but they also have the potential of helping to reconnect people.

Since I'm often "the mindfulness guy," I'd like to underscore something that Bessel said about the early days of the Center for Mindfulness and Medicine, University of Massachusetts, when he would send people off to do a mindfulness-based stress-reduction program. A lot of Bessel's trauma patients would drop out.

> "If we have a significant trauma history, mindfulness practice is at the ***end*** of doing all this other work."

That's because if we have a significant trauma history, mindfulness practice is the Capstone course; that's at the *end* of doing all this other work that we've been talking about: the kind of mindfulness practice in which you're just sitting still with the breath for a projected period of time.

That doesn't mean you can't do other practices that are grounding practices that have a mindfulness component – like walking meditation, nature meditation, eating meditation, and things that bring us into the present with an outer or distal focus.

But if we're just going to stay with, "Let's see what comes up in here," that really is the "advanced course." We have to be careful not to move *there* too quickly.

> "With lovingkindness and self-compassion practices, we ***really*** have to think about the window of tolerance."

Similarly, with lovingkindness and self-compassion practices, we *really* have to think about the window of tolerance. We don't want to bathe the person in love in a way that's suddenly going to connect them with all of their horrors, all of the ways they feel unloved and the like.

So at the same time that we're focusing on certain techniques, we need to be particularly judicious about other techniques in which the right context can be very helpful but easily bring people out of the window of tolerance.

Dr. Buczynski: Thank you. That's it for us for tonight.

It is *so important* that we get this right, that we learn the best, the latest that we have about how to help people cope with and heal from trauma.

So, your work is important; when you help someone heal, it makes a difference. It has a ripple effect that makes a difference *way* beyond what you see – and I just want to say thank you to everyone for that.

"At the same time that we're focusing on certain techniques, we need to be particularly judicious about other techniques."

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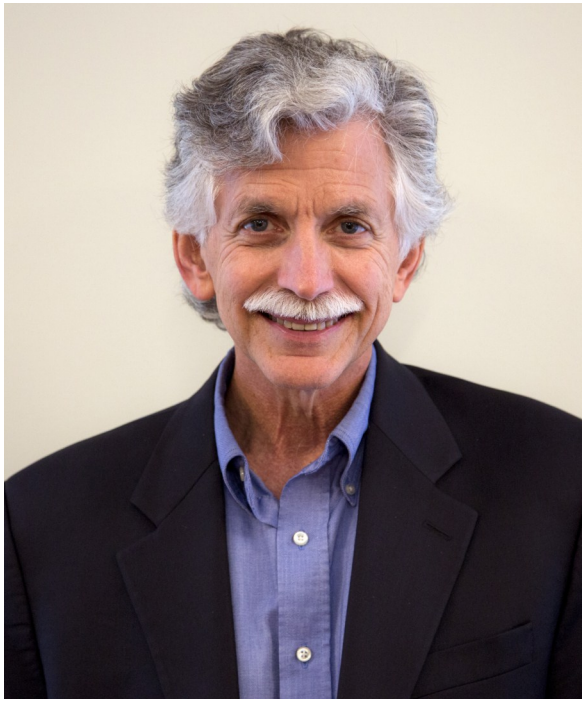
About the Speakers . . .

Ruth Lanius, MD, PhD is a professor of Psychiatry and the director of the PTSD Research Unit at the University of Western Ontario. She established the Traumatic Stress Service and the Traumatic Stress Service Workplace Program, both specializing in the treatment and research of PTSD and related comorbid disorders. She currently holds the Harris-Woodman Chair in Mind/Body Medicine at the Schulich School of Medicine and Dentistry at the University of Western Ontario.

She has authored more than 100 published papers and chapters in the field of traumatic stress, regularly lectures on the topic of PTSD nationally and internationally, and has published *Healing the Traumatized Self: Consciousness, Neuroscience, Treatment*, together with Paul Frewen.

Ron Siegel, PsyD is an Assistant Clinical Professor of Psychology at Harvard Medical School, where he has taught for over 20 years. He is a long time student of mindfulness mediation and serves on the Board of Directors and faculty for the Institute for Medication and Therapy.



Dr. Siegel teaches nationally about mindfulness and psychotherapy and mind/body treatment, while maintaining a private practice in Lincoln, MA.

He is co-editor of *Mindfulness and Psychotherapy* and co-author of *Back Sense: A Revolutionary Approach to Halting the Cycle of Chronic Back Pain.*