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Somatic Experiencing

*A Body-Centered Approach
To Healing Veterans' PTSD*

This new approach to treating PTSD is based on the assumption that trauma is an experience that affects and imprints the body, so it's essential to engage the body in the healing process.

By J. Scott Janssen, MSW, LCSW

With tension and military conflict around the world, it's no surprise that the rate of PTSD among veterans and active military personnel is significantly higher than in the general population. Some argue that the statistics underestimate the true number of vets struggling with trauma, emphasizing that PTSD often intertwines with other physical and psychological conditions, thus making it easy to underdiagnose. Many veterans minimize their symptoms or don't seek help due to stoicism, distrust, fear of stigma, or lack of access to assistance. Among those who do seek care, many do so informally or outside of the VA system and may not be represented in official statistics.

Though there are many treatment approaches, the standard psychotherapeutic intervention for veterans with PTSD involves a combination of prolonged exposure, in which a veteran is encouraged to talk repeatedly and in minute detail about the events of the trauma, and cognitive behavioral therapy. The idea is that reliving traumatic experiences will allow veterans to reconsolidate painful memories in a safe and supportive context. During the course of this retelling, the hope is that troubling thoughts and beliefs will be reframed, emotions cathartically released, and that survivors will become less reactive to traumatic triggers. Though this approach has helped many vets, many others who start such treatment become frustrated or overwhelmed and do not finish.

Exploring the Body

In recent years the search has been on for new approaches that can enhance the effectiveness of current treatments. Among those showing promise are so-called body-centered or somatic approaches to healing trauma, such as somatic experiencing (SE). These approaches share the assumption that trauma is first and foremost an experience that affects and imprints the body and that it's essential to engage the body in the healing process.

"If social workers are not asking their clients about their bodies, they are missing out on reams of information," says Susan Pease Banitt, LCSW, RYT, a social worker, educator, and author of *The Trauma Tool Kit: Healing PTSD from the Inside Out*. "Neuroscience shows us that PTSD affects many systems of the brain and body directly: the hypothalamic-pituitary-adrenal axis, which governs the endocrine system, the entire nervous system, the circulatory system, and others."

For SE practitioners (SEPs), trauma is a response to an event that dysregulates the normal physiological processes of the nervous system, keeping it in a constant state of threat response. It's this ongoing physiological activation that affects a vet's mind, emotions, relationships, behavior, and sense of self. Peter Levine, PhD, founder of SE, explains it this way: "Traumatic symptoms are not caused by the event itself. They arise when residual energy from the experience is not discharged from the body. The energy remains trapped in the nervous system where it can wreak havoc on our bodies and minds."

According to Levine, PTSD occurs when one branch of the nervous system generates massive amounts of survival (fight or flight) energy to meet a threat, only to find the threat so

overwhelming that there's no way to use this energy for self-protection. For combat veterans, these situations may occur with lightning-like speed such as with the detonation of an improvised explosive device (IED) or an injury sustained in a roadside ambush. Such situations block this survival energy from being discharged through movements such as fighting, escaping, or simply orienting toward a threat that seems to come out of nowhere. When this happens, another branch of the nervous system kicks in and shuts the body down into a state of collapse and immobility, "trapping in," as Levine puts it, all that survival energy.

Ordinarily when these defensive impulses are overwhelmed or interrupted, the nervous system has natural ways of restoring equilibrium such as shaking, involuntary movements, or spontaneous alterations in breathing. These let the body know the threat has passed and it's safe to return to normal. Unfortunately, soldiers trained in a code that values self-discipline, action, and the masking of fear are apt to suppress these natural restorative processes. When this happens the nervous system fails to realize the threat has passed and becomes stuck on high alert, creating the reactive, hyperaroused states characteristic of many symptoms of PTSD such as hypervigilance, anxiety, emotional flooding, insomnia, and an exaggerated startle response. When veterans attempt to shut down this arousal, or when they get stuck in a physiological state associated with immobility, nervous system dysregulation and PTSD can manifest in opposite symptoms such as emotional numbing, flat affect, or depression.

Given that the nervous system is integral to so many bodily systems including the circulatory, immune, digestive, respiratory, and endocrine, a persistent state of heightened alert and fear can take a great toll. Many veterans with PTSD attempt to mute the intensity of this chronic nervous activation through social withdrawal, avoidance of stimuli, numbing, or by abusing substances. By the time they begin counseling many have come to see their bodies as something to fear, dissociate from, or brace against as their nervous systems repeatedly respond to perceived threats.

Rather than starting with a focus on the trauma narrative, SE starts by enhancing veterans' awareness of the energy and physical sensations occurring in their bodies. This includes pleasant sensations, which have often gone unnoticed, as preparation for moving toward the unpleasant ones. When details of the trauma story emerge, they are taken in small pieces with an eye on accessing physical sensations, subtle motor patterns suggesting survival responses, and discreet imagery, rather than cognitive processing, reliving, or cathartic emotional release. Starting with the body builds strategies for staying grounded when these explorations are made and "provides a lens," says Nancy Krisel, LCSW, LCAS, SEP, who works at the VA in Asheville, North Carolina, "for seeing what's going on with the client's nervous system and physiology below the surface of thoughts and feelings."

Pease Banitt agrees that bringing the body into the healing process makes sense, but reminds social workers unfamiliar with such explorations to move cautiously when working with

survivors of trauma. “Waking up the body to trauma is like putting a hypothermic part of the body in warm water. The first thing that happens is pain. If you can survive the pain then you can heal,” Pease Banitt says.

SE trainer Dave Berger, MFT, LCMHC, PT, MA, SEP, agrees: “Veterans have been exposed to severe degrees of life-threatening and integrity-threatening experiences. It’s a natural biological response to such experiences to shut down feeling states to avoid being so overwhelmed.” He says this is why SE takes things slowly, starting by establishing a safe environment, gently increasing somatic awareness, and emphasizing the core concepts of resourcing, pendulation, and titration.

Resourcing refers to helping a veteran identify and build resources for “going inside” the body and staying grounded while experiencing uncomfortable sensations, emotions, or memories. Resources may be internal, such as a sense of inner strength, or external, such as having a supportive partner. In the here and now of the therapeutic encounter, a primary resource is enhancing a client’s ability to both notice and track his or her physical sensations, sensory-motor gestures, and impulses. Ideally, this fosters curiosity about one’s sensory experience and an increased ability to respond mindfully rather than reactively to strong feelings and sensations as they arise.

Pendulation refers to the natural biological rhythm through which the body maintains a sense of flow, as the nervous system fluctuates between states of activation and relaxation. According to Berger, pendulation is a “natural biological function allowing us to relax, get amped up, and relax again” but for those with PTSD, this rhythm “gets disrupted.” Traumatized veterans may become quickly overactivated and have a hard time calming their systems without going to extremes such as dissociation or withdrawal. SE helps survivors rediscover this natural rhythm. This may begin very simply. For example, vets may notice that as they bring attention to their shoulders they go from feeling tense to relaxed, or that compression in the chest begins to dissolve.

Regaining this capacity to pendulate naturally between activation and relaxation, constriction, and expansion, is an important step in reregulating one’s nervous system and reducing its reactivity to triggers. It’s also important in psychological terms, reminding veterans that distressing states are not permanent (which is often how it feels to someone with PTSD), but are a transient part of the flow of one’s life and one can learn to alternate back to a state of peace.

Rather than pushing a veteran to tell the trauma story chronologically and in detail, social workers using SE take the trauma material in very small pieces, called titration. The intention is to repeatedly stimulate then settle the physiological activation associated with the trauma. Often this begins with the least threatening aspects of the traumatic event (for example, something that happened prior to an ambush). This is referred to as “working from the periphery” and is considered important because moving too quickly into charged traumatic material can be overwhelming and potentially retraumatizing.

Berger says the idea is to “pause the story when there is nervous activation, fear, or anxiety present and allow it to dissipate before moving forward.” SE practitioners encourage veterans to “touch into” the trauma just enough to notice changes in sensation or affect, then settle this energy before proceeding.

“This may mean taking things just one frame at a time, frame-by-frame,” Krisel says. A veteran, for example, might be encouraged to focus on what happens physically as she imagines a triggering image (the position of the sun when an attack occurred), belief (I’m not safe at night), behavior (entering a crowded room), or a troubling affect or memory.

Krisel finds that when she introduces these concepts to veterans “it gives them a way to understand why they have such intense physiological responses to triggers—sweaty palms, racing heart, altered respiration, and so on.” By enlisting the body as an ally and source of information, normalizing their responses, taking things slowly and learning to pendulate, she says veterans gain increased confidence that “they are in control. The trauma is not in control of them.”

Categories of Human Experience

SE uses the acronym SIBAM to divide human experience into the broad categories of sensation, image, behavior, affect, and meaning. In cases of trauma, where sensory and visual memory are often very fragmentary, these aspects of experience get fused or “overcoupled” and become a source of traumatic triggers. For example, the sound of a child gurgling milk (classified as an image) might instantly create fear (affect) and rapid breathing (sensation) for a veteran whose subcortical brain registers the sound of blood filling in the lungs of a friend during the Vietnam War. These associations are automatic, unconscious, and, in a nervous system constantly on guard for threats, pervasive. Complicating the picture is the fact that these experiential elements not only fuse with each other, but they also generate automatic, stimulus-response reactions from the nervous system. Fear, for example, is often overcoupled with the physiological experience of immobility. In such cases any experience of fear can instantly lead to a state of shut down and, reciprocally, any physical sensations that the subcortical regions of the brain associates with immobility might instantly generate fear.

Berger offers the example of a client who served in the Iraq War for whom “sitting still” was a source of distress. In the course of therapy, they discovered that the behavior of sitting still had become overcoupled with fear and an instantaneous autonomic nervous system response as if preparing for an attack. This soldier, it turns out, had been attacked after he and his commander had gotten out of their vehicle to take a quick break.

Pease Banitt recalls a veteran who had a panic attack while in a restaurant, providing a good illustration of how nervous activation and elements of combat-related trauma can easily be grafted onto seemingly innocuous cues and triggers in civilian life. “When we traced it back there were three massive triggers: getting boxed in physically, seeing camo fatigues on his way in, and a third, much less obvious trigger, a freeze

headache. Apparently freeze headaches were common in the desert where he was stationed.”

Uncoupling these elements and restoring a natural flow to the nervous system is a primary goal of SE. This is done, as with everything else, by remaining attentive to somatic, affective, and sensory-motor experience, working in the here and now, using the body’s “felt sense” as a source of information and learning to pendulate through difficult experiences rather than overreacting or becoming overwhelmed by them.

In the course of this uncoupling, veterans typically notice impulses in their bodies to move in ways that suggest natural self-protective responses that had been blocked during the traumatic event. Krisel says these impulses often suggest fighting, defending, or running. When they appear, she invites clients to follow them and notice what happens in their bodies, often asking, “What does your body want to do now that it didn’t get to do then?”

Allowing one’s body to complete these previously inhibited defensive responses within the safe context of a therapeutic setting releases bound nervous energy and provides a corrective bodily experience for feelings of helplessness and fear. It also sends a message to the body and nervous system that the threat has passed; it’s safe to return to a state of balance.

Interested readers can find video excerpts on YouTube of sessions with Levine and an Iraq War veteran named Ray who was injured by simultaneous IED explosions. When Ray arrives, he exhibits Tourette’s syndrome-like spasms in his neck that cause his head to jerk involuntarily. During

the sessions it becomes apparent that this motion is his body’s attempt to orient in the direction of the blast and protect himself (something he hadn’t been able to do at the time). Levine encourages Ray to follow the movement and rotate his head more fully in the direction of the spasm. This allows him to complete the defensive response that was interrupted during the traumatic event, discharging the energy stored in his nervous system, and quickly reducing the intensity of the spasms (which disappear over the course of these sessions).

Berger says the ultimate goal of SE is to “renegotiate” the response to the trauma by helping clients access their innate resilience, reregulate their nervous systems, and heal their minds, hearts, and relationships so that “history can become history instead of living as if the trauma is still in the present.”

Although SE was developed as a comprehensive model specifically for working with trauma, Berger acknowledges there are many other approaches, pointing out that “with complex PTSD, there are often multiple ‘systems’ that need to be addressed—psychological, nutritional, relational, physical.” For social workers working with veterans or any survivors of trauma, he says, “the concepts and principles of SE can be adapted to provide important new dimensions to care and integrated into virtually any existing approach.”

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