SESSION 1

- Trauma impacts our bodies!
- It is a supremely physical phenomenon
- Trauma pushes us beyond our normal coping capacities – something that we cannot process or deal with
SESSION 1

- Bessel van der Kolk’s definition of trauma: ‘an inescapably stressful event that overwhelms people’s existing coping mechanisms’
- American Psychological Association: traumatic stress involves ‘intense fear, helplessness, or horror’

SESSION 1

- Trauma is life-threatening powerlessness
- Powerlessness is the very essence of trauma
- Powerlessness is both psychological and physical – and needs to be tackled on both levels if we are to recover
Session 1

- Traumatic stress kick-starts a series of physical responses:
  - Good for us short-term
  - Bad for us long-term
  - Our focus as survivors can be on the wrong thing

- Traumatic stress leads to a range of physical issues:
  - in the brain
  - in the major organs of the body
  - in the immune system
  - in the stress response system itself
SESSION 1

• Childhood trauma profoundly affects the way the brain organises and processes its experience
• Our brains become geared towards **sensing** and **responding to threat**

SESSION 1

• The trauma worldview tells us:
  • that the world is not safe
  • that we are powerless to act effectively in the face of threat
  • that recovery is not really possible
SESSION 1

• Recovery is possible!
• The impact of trauma is physical as well as psychological
• Unresolved trauma is the greatest threat to my physical health

SESSION 1

• 7.7x more like to suffer a stroke (Brass & Page, 1996)
• 5x more likely to die after a heart attack (Musselman et al, 1998; Rozanski et al, 1999)
• 62% increased risk of heart disease (Rich-Edwards et al, 2011)
• 2x more likely to develop chronic fatigue syndrome (Fuller-Thomson & Sulman, 2011)
• 65% higher risk of fibromyalgia (Fuller-Thomson & Sulman, 2011)
• 4.7x more likely to develop irritable bowel syndrome (Surdrea-Blaga, Baban & Dmuitrascu, 2012)
• 49% increased risk of cancer in adulthood (Fuller-Thomson & Brennenstuhl, 2009)
• 85% failure rate of back surgery for abuse survivors (as opposed to 5% for non-abused patients) (Schofferman et al, 1992)
SESSION 1

- Is this a physical issue or a psychological one?
- Do you have a physical illness or a mental one?
- Is sleep an issue for a therapist or a GP?

SESSION 1

- Aristotle’s ‘lunatics’
- Mental disorders were thought of as ‘supernatural’
- Fine line between sainthood and demonisation!
Chaining patients was widespread until 1793
= ‘humane treatment approaches’

Mentally ill people were considered to be dangerous, criminal and subhuman
SESSION 1

- Descartes: **cogito ergo sum**
- ‘Turf deal’ with the Pope:
  - Mind, soul, emotions belong to the church
  - Science got the bodies!

SESSION 1

- WW1: ‘shell shock’ = shot for cowardice
- Difficulties in obtaining welfare benefits
- ‘Lazy’, ‘cowardly’, ‘weak’
- Symptoms of trauma affect people who have been traumatised!
Trauma and the Body: Somatisation and Dissociation

Carolyn Spring

What is your experience of mental health attitudes?

In what ways do you see the mind-body split in your professional work?

Why do you think that trauma leads to such increased risk for major disease?
SESSION 2

• Getting ill on holiday
• ‘Mind-body’
• Many trauma survivors suffer many physical complaints
SESSION 2

- Getting ill on holiday
- ‘Mind-body’
- Many trauma survivors suffer many physical complaints

SESSION 2

- Getting ill on holiday
- ‘Mind-body’
- Many trauma survivors suffer many physical complaints
- ‘Trauma tummy’!
SESSION 2

• Shame around the body
• Ambivalent: hate it, but ‘Please don’t notice it!’
• Dissociate from it: ‘I don’t have any feet!’
• We see our bodies as the source of the abuse/pain

SESSION 2

• I had to put the blame where it belonged and take it off my body
• I had to stop treating my body like it was the problem
• We need to treat our bodies differently from the way they have been treated
SESSION 2

• Avoidance of the body / self-neglect
• Many trauma survivors find it difficult to access healthcare
• Our bodies don’t ‘work’ the way they should

SESSION 2

• Trauma is a threat, real or perceived, to our bodily integrity
• ‘Life-threatening powerlessness’
• We are wired to survive threat by utilising our autonomic nervous system
SESSION 2

“They are complementary and help to balance the body.

• The sympathetic nervous system is like the accelerator.
• The parasympathetic nervous system is like the brake.
SESSION 2

- **Green** (parasympathetic, myelinated)
  - Safe environment
  - **Social engagement**
  - Feed and breed / rest and digest
### SESSION 2

- **Green** (parasympathetic, myelinated)
  - Safe environment
  - **Social engagement**
  - Feed and breed / rest and digest
- **Amber** (sympathetic)
  - Threat in the environment
  - **Mobilisation**
  - Fight and flight
- **Red** (parasympathetic, non-myelinated)
  - Overwhelming threat
  - **Immobilation**
  - Freeze
SESSION 2

• Red and amber states are toxic to our health
• ‘Recovery’ can be seen as retraining the body/mind to live principally in the green zone

SESSION 2

• Attack or threat
• Instant response
• Amygdala responds within around 7 milliseconds
SESSION 2

• Attack or threat
• Instant response
• Amygdala responds within around 7 milliseconds
• ‘Smoke alarm’ sets off an alarm to trigger the sympathetic nervous system

SESSION 2

• Signal to secrete neurotransmitter noradrenaline in the brain
  • Supercharges part of the brain
• Hypothalamus sends a message to the pituitary gland
SESSION 2

- Signal to secrete neurotransmitter noradrenaline in the brain
  - Supercharges part of the brain
  - Hypothalamus sends a message to the pituitary gland
    - This sends a message to the adrenal medulla
    - This releases adrenaline and noradrenaline into the bloodstream

SESSION 2

- Effects of adrenaline:
  - Heart beats faster and stronger
  - Blood vessels constrict to raise blood pressure
SESSION 2

• Effects of adrenaline:
  • Heart beats faster and stronger
  • Blood vessels constrict to raise blood pressure
SESSION 2

• Effects of adrenaline:
  • Heart beats faster and stronger
  • Blood vessels constrict to raise blood pressure
  • Blood supply shifts to brain and muscles

SESSION 2

• Other effects:
  • Spleen releases more red blood cells
SESSION 2

• Other effects:
  • Spleen releases more red blood cells
  • Liver converts energy stores to glucose

SESSION 2

• Other effects:
  • Spleen releases more red blood cells
  • Liver converts energy stores to glucose
  • Breathing speeds up and becomes heavier
SESSION 2

• Other effects:
  • Spleen releases more red blood cells
  • Liver converts energy stores to glucose
  • Breathing speeds up and becomes heavier
  • Pupils dilate

SESSION 2

• Cortisol prepares us for an extended stress
• Complements many of the responses of adrenaline but has some extra impacts:
  • Increases cholesterol
  • Shunts energy away from the reproductive system
  • Affects the immune system
SESSION 2

- Suppresses the inflammatory response
- Synthetic cortisol = hydrocortisone cream
- Anti-inflammatory agent for insect bites, itches, rashes

SESSION 2

- Adrenaline (fast response) is deactivated within about 5 minutes
- Cortisol (slow response) takes about 2 hours to clear from the bloodstream
SESSION 2

- Chronic amber state of mobilisation puts us at risk for disease
- ‘Corrosive cortisol’
- Made in our adrenal glands on top of our kidneys
- Primary function is to metabolise energy

SESSION 2

- Weight gain – increases blood sugar levels
  - ‘Catabolic’ effect on muscles
  - Increases appetite and cravings
  - Burns peripheral (good) fat but lays down visceral (bad) fat
- Keeps blood sugar levels high
  - Insulin resistance
SESSION 2

- Heart disease
- Diet less of a contributing factor than stress
SESSION 2

• Heart disease
• Diet less of a contributing factor than stress
SESSION 2

- Heart disease
- Diet less of a contributing factor than stress
- Cortisol raises:
  - Blood pressure
  - Cholesterol
- Causes damage to blood vessels
- Chronic stress raises risk

SESSION 2

- Cancer
- 49% increased risk for trauma survivors
- Increased lifestyle risks
- Direct impacts as well
  - Hormone imbalances
  - Immune system
Generally speaking, the immune system is suppressed during stress.

But there is an initial burst of super-immunity.

Sometimes it doesn’t fall back to baseline.

A schematic representation of how repeated stress increases the risk of autoimmune disease (Sapolsky, 2004).
• Generally speaking, the immune system is suppressed during stress
• But there is an initial burst of super-immunity
• Sometimes it doesn’t fall back to baseline
• Numerous ‘transient stressors’ can ratchet the baseline higher over time, leading to autoimmune disorders

• Trauma seems to set the stage for a number of physical processes to go wrong
• Gabor Maté: ‘When the Body Says No’
Trauma seems to set the stage for a number of physical processes to go wrong

- Gabor Maté: ‘When the Body Says No’
- Shawn Talbott: ‘The Cortisol Connection’

<table>
<thead>
<tr>
<th>Metabolic effect (cortisol-induced)</th>
<th>Chronic health condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased appetite, accelerated muscle catabolism (breakdown), suppressed fat oxidation, enhanced fat storage</td>
<td>Obesity</td>
</tr>
<tr>
<td>Elevated cholesterol and triglyceride levels</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Elevated blood pressure</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Alterations in brain neurochemistry (involving dopamine and serotonin)</td>
<td>Depression/anxiety</td>
</tr>
<tr>
<td>Physical atrophy (shrinkage) of brain cells</td>
<td>Alzheimer’s disease</td>
</tr>
<tr>
<td>Insulin resistance and elevated blood-sugar levels</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Accelerated bone resorption (breakdown)</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Reduced levels of testosterone and oestrogen</td>
<td>Suppressed libido (reduced sex drive)</td>
</tr>
<tr>
<td>Suppression of immune-cell number and activity</td>
<td>Frequent cold/flu/infection</td>
</tr>
<tr>
<td>Reduced synthesis of brain neurotransmitters</td>
<td>Memory/concentration problems</td>
</tr>
</tbody>
</table>

Source: The Cortisol Connection by Shawn Talbott
How can you safely help trauma survivors access healthcare services?

Using the traffic light analogy, which way do you (or your clients) tend to respond to stress – by going into amber or red?

Have you previously seen disease processes such as cancer, diabetes and heart disease as being connected to trauma?
SESSION 3

• **Green** (parasympathetic, myelinated)
  - Safe environment
  - **Social engagement**
  - Feed and breed / rest and digest

• **Amber** (sympathetic)
  - Threat in the environment
  - **Mobilisation**
  - Fight and flight

• **Red** (parasympathetic, non-myelinated)
  - Overwhelming threat
  - **Immobilisation**
  - Freeze

SESSION 3

• Fight-and-flight response makes sense!

• I became **physiologically habituated** to switching straight to a freeze response (a dissociative response)

• Freezing is a survival response
SESSION 3

- Parasympathetic nervous system kicks in
- Unmyelinated branch of the vagus nerve
- Flood of endogenous opioids (‘homemade heroin’)
- Pain response is numbed
- Freeze is to the body what dissociation is to the mind
- Attention is narrowed
- ‘Depersonalisation’ and ‘derealisation’

SESSION 3

- Peter Levine proposed that PTSD etc is a result of not discharging the freeze response
- Animals discharge the freeze response with violent trembling or shaking
• Recovery is by ‘shaking out’ the trauma
• Breathing re-regulates the ANS and stimulates the vagus nerve
• ‘Completing’ the actions of fight and flight that the body wanted to do at the time
SESSION 3

• We have to teach **all** parts of our brain (including our primitive back brain) that we are no longer powerless
• Study by Amy Cuddy and Dana Carney on power posing
• Pierre Janet: ‘acts of triumph’
• We freeze in response to **all** kinds of stress, not just traumatic stress

At a time when you have felt helpless in the past, what is that your body would have done if it could have done?

What ‘acts of triumph’ are there in your life?

In what ways have you ‘forgotten’ how to engage active responses in your life?
Trauma and the Body: Somatisation and Dissociation

by Carolyn Spring

SESSION 4

- Martin Seligman: ‘learned helplessness’
- ‘Inescapable shock’
- The more shocks the animal receives, the less often it tries to escape
- It loses the ability to act in the face of stress or trauma
- It remains in ‘freeze’
SESSION 4

• We can develop a conditioned response and ‘freeze’
• We ‘freeze’ even if the ‘barriers’ have been removed
• If we ‘freeze’ (dissociate) when we’re stressed, that’s a dissociative disorder

SESSION 4

• Powerlessness (‘learned helplessness’) is our core reaction to trauma
• It is frustrating to people around us and can deeply impact our relationships
• We mustn’t make friends with our barrier!
• We need to see that reality is not always what we think it is
SESSION 4

• Faa or Baa?
• ‘Top down processing’ and ‘bottom up processing’
• (Pat Ogden, ‘Trauma and the Body’ and Daniel Siegel, ‘Mindsight’)

SESSION 4

• Mindfulness is a key way to begin to ‘unfreeze’ our brains
• Mindfulness is directed, focused attention
• A raft of studies show the health benefits of mindfulness
• It also reduces cortisol
## Dissociation vs. Mindfulness

<table>
<thead>
<tr>
<th>Dissociation</th>
<th>Mindfulness</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m not here (derealisation)</td>
<td>I am here (presentification)</td>
</tr>
<tr>
<td>I’m not me (depersonalisation)</td>
<td>I am me (personification)</td>
</tr>
<tr>
<td>Drifting off</td>
<td>Being grounded</td>
</tr>
<tr>
<td>Attention elsewhere (often the there-and-then)</td>
<td>Attention on the here-and-now</td>
</tr>
</tbody>
</table>

### SESSION 4

- Mindfulness engages the media prefrontal cortex (front middle brain)
- Daniel Siegel: ‘Mindsight’
- Mindfulness enhances **neuroplasticity**
- It helps our ‘noticing’ brain realise that the barrier is no longer there
- ‘Headspace’ app: [www.headspace.com](http://www.headspace.com)
SESSION 4

- Automatic reaction to trauma: fight, flight, freeze
- The more trauma, the more likely we are to freeze
- A conditioned **bodily** response
- We can develop learned helplessness
- We need to recognise powerlessness
- We need to reassess: 'Baa' or 'Faa'?

SESSION 4

What did you think of the 'Faa Baa' clip? Could you override what your eyes were telling you?

What barriers does your brain still 'see' that might not be there?

What role does learned helplessness play in your life?
SESSION 5

• **Green:**
  • Feed and breed / rest and digest
  • No associated health risks
• **Amber:**
  • Fight and flight
  • Health risks from **too much** cortisol
• **Red:**
  • Freeze
  • Health risks from **too little** cortisol
Women who have been physically abused in childhood:

- Twice the odds of developing CFS
- 65% higher odds of developing fibromyalgia
- 3-8-fold increased risk depending on the trauma

A disturbance of the HPA axis:

- Hypothalamus
- Pituitary
- Adrenal

- Disturbed cortisol levels
- Chronic over-activation of fight-or-flight
- Exhaustion of amber state leading to a red state of immobilisation
SESSION 5

• Dr Sarah Myhill:
  ‘Diagnosis and Treatment of Chronic Fatigue Syndrome’
• www.drmyhill.co.uk
• CFS/ME caused by mitochondrial failure

SESSION 5

• Mitochondria are the ‘engines’ of cells
• The ‘fuel’ for cells is ATP: adenosine triphosphate
• Adenosine molecule with 3 phosphate ions
• To release energy in the cell, a phosphate ion is released
• ATP becomes ADP (adenosine diphosphate = 2 phosphate ions)
ADP (two ions) can usually be recycled back up to ATP (three ions)

This recycling doesn’t happen (or not quickly enough) in CFS/ME

ADP degrades to unrecyclable AMP (one ion)

Need more B-vitamins, Co-Q10, magnesium

One of the signs of lack of ATP is lactic acid (‘stich’) – causes pain

In severe CFS/ME the body’s supplies of ATP are used up just existing

Dr Arnold Peckerman: CFS/ME is effectively heart failure

The heart muscles have insufficient ATP leading to low cardiac output

CFS/ME = ‘borderline heart and organ failure’ (Dr Sarah Myhill)
SESSION 5

- Conceptualising CFS/ME as a red alert state of exhaustion
- The key for me has been resolving the underlying trauma
- With unresolved trauma, the brain hasn’t registered that the trauma is over
- So the autonomic nervous system keeps sounding the alarm

SESSION 5

To what extent do you believe that recovery from trauma is physical as well as psychological?

How might you need to adapt the services you provide to enable clients with chronic health conditions to access trauma therapy?

How can you help the survivor’s back brain begin to recognise that the trauma is over so that the alarm stops sounding?
Session 6

- ‘Grey’ pain
- ‘Electric’ pain
- Chronic pelvic pain
- Allodynia (non-painful things are painful)
- Hyperalgesia (painful things are extra-painful)
- Analgesia (painful things aren’t painful)
- Over-sensitive empathy response
- Lactic acid
- Joint pain / fibromyalgic inflammation
SESSION 6

- More powerless
- Feels like punishment
- Retriggers old memories
- Intensely lonely experience
- Vicious cycle
- But my pain levels have improved probably by around 70%

SESSION 6

- Purpose of pain:
  - To signal injury or disease
  - Memories of pain help us avoid danger
  - Forces us to rest
Session 1.1

• Pain is not always proportional to the damage
  • Massive damage, little pain
  • Small damage, lots of pain

Tissue damage heals in 3-6 months, but chronic pain continues beyond this
• Pain is affected by:
  • Meaning
  • Cultural background
  • Anticipation
  • Control

Melzack and Wall, ‘The Challenge of Pain’:

‘Pain is a unified stream of experience that is generated by the brain and is influenced by all of its cognitive functions such as memories of prior experiences and the meaning of the current situation.’

‘... pain experience must not be confused with physical injury or disease. The perceptual qualities of pain are produced by built-in neural networks in the brain which may be activated by sensory inputs but can also be generated spontaneously.’
Maggie Phillips, ‘Reversing Chronic Pain’:
‘Pain is not simply a function of the amount of bodily damage alone. Rather, the amount and quality of pain we feel are also determined by our previous experiences and how well we remember them, by our ability to understand the cause of the pain and to grasp its consequences.’

- My perception of pain is affected by:
  - My memories
  - My expectations
  - My sense of threat
  - The meaning I’ve attributed to it
  - My mood and other psychological factors
  - ‘Kindling’
• Melzack & Wall's theory of a pain ‘gate’:
  • Some things can ‘open’ the gate
  • Some things can ‘close’ the gate

<table>
<thead>
<tr>
<th>What opens the gate (increases pain)</th>
<th>What closes the gate (decreases pain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of sleep or disrupted sleep</td>
<td>Good rest and sleep</td>
</tr>
<tr>
<td>Stress</td>
<td>Relaxation and self-treatment</td>
</tr>
<tr>
<td>Anxiety and fear about pain levels</td>
<td>Confidence in using tools to block or interrupt pain</td>
</tr>
<tr>
<td>Depression</td>
<td>Increased serotonin</td>
</tr>
<tr>
<td>Deficit of endorphins</td>
<td>Increased endorphins through exercise and other experiences</td>
</tr>
<tr>
<td>Nutrients that increase inflammation, e.g. processed foods, caffeine etc</td>
<td>Nutrients that decrease inflammation, eg those containing omega-3, magnesium and B-vitamins</td>
</tr>
<tr>
<td>Repeated trauma to the injury area</td>
<td>Techniques to relieve pain areas; avoidance of unnecessary surgery or invasive medical procedures</td>
</tr>
<tr>
<td>Boredom, inactivity, too much activity</td>
<td>Increased activity in daily activities; appropriate activity levels</td>
</tr>
</tbody>
</table>
SESSION 7

- You don’t need to have a body to feel a body
- You don’t need to have tissue damage to feel pain
- All pain exists in the brain
Three pathways for my chronic pelvic pain:

- ‘Misfiring’ of the pain system
- Pain as somatic memory
- Somatisation

Somatisation is ‘a tendency to experience and communicate somatic distress in response to psychosocial stress’ (Lipowski)

An ego-defence: the unconscious channelling of repressed emotions into somatic symptoms
Somatisation is when we feel emotions through bodily symptoms rather than as feelings.

Somatic disorders are common in patients ‘in whom emotion is undifferentiated and unregulated’ (Graeme Taylor).

High proportion of somatic patients are alexithymic.

- Alexithymia is a condition where we find it difficult to put words to our feelings.
- Scene of the crime: the right orbitofrontal cortex.
• Right orbitofrontal cortex (‘front right brain’)
  • Involved in attachment and relationships
  • Links emotions with the body
  • Involved in regulating levels of cortisol
  • Linked to the immune system

• Poor relationships and unexpressed emotions make us ill!
• Part of the process of therapy is learning to express our emotions as feelings rather than as physical symptoms
In what ways does your body communicate your emotions?

If a part of your body (that is unwell or is in pain) could speak, what might it say to you?

In what ways do you listen to your body?
SESSION 8

- Is traumatic amnesia for real?
- ‘Denial of the syndrome is part of the syndrome’ and ‘denial and dissociation are two sides of the same coin’
- The more distressing an event, the more likely it is for amnesia to occur

SESSION 8

- By ‘memory’ we tend to mean ‘explicit’ memory – episodes and facts
• By ‘memory’ we tend to mean ‘explicit’ memory – episodes and facts

• There are multiple memory systems in multiple parts of the brain

• ‘Implicit’ and ‘explicit’ memory

• The hippocampus mediates explicit memory (episodic, narrative, semantic)
• The hippocampus mediates explicit memory (episodic, narrative, semantic)

• The amygdala mediates implicit memory (procedural learning, conditional)

<table>
<thead>
<tr>
<th>Process</th>
<th>Explicit (declarative)</th>
<th>Implicit (non-declarative)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information types</td>
<td>conscious</td>
<td>unconscious</td>
</tr>
<tr>
<td></td>
<td>cognitive facts</td>
<td>emotional conditioning</td>
</tr>
<tr>
<td></td>
<td>mind</td>
<td>body</td>
</tr>
<tr>
<td></td>
<td>verbal/semantic</td>
<td>sensory</td>
</tr>
<tr>
<td></td>
<td>descriptions of operations and procedures</td>
<td>automatic skills and procedures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mediating limbic structure</th>
<th>hippocampus</th>
<th>amygdala</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maturity</td>
<td>around 3 years</td>
<td>from birth</td>
</tr>
<tr>
<td>Activity during traumatic event</td>
<td>suppressed</td>
<td>activated</td>
</tr>
<tr>
<td>Language</td>
<td>constructs narrative</td>
<td>speechless</td>
</tr>
</tbody>
</table>
SESSION 8

• The amygdala never forgets, but the hippocampus does
• The hippocampus works on an ‘inverse-U’ basis
  • A bit of stress and it’s enhanced
  • A lot of stress and it’s shut down

• Edouard Claparède, a neurologist at the beginning of the 20th century
• His patient had a damaged hippocampus and couldn’t form new ‘explicit’ memories
• But she had an implicit memory of his ‘attack’!
SESSION 8

- Implicit memory – ‘body memories’ – warn us of danger
- In trauma, we are dominated by our survival-based back brains (amygdala) rather than our choosing, thinking front brains (hippocampus)
- Making the implicit explicit
Session 1.1

- Traumatic events as stored weakly in explicit memory and strongly in implicit memory
- Flashbacks and triggers are clues and the ‘footprint’ of implicit memory
- We need to keep the hippocampus online when processing traumatic memory

Session 8

- The hippocampus is a ‘context stamp’
SESSION 8

• The hippocampus is a ‘context stamp’
• Marks events (memories) as ‘over’, ‘past’
• We are in our ‘window of tolerance’ if we can both think and feel at the same time

SESSION 8

• The hippocampus is a ‘context stamp’
• Marks events (memories) as ‘over’, ‘past’
• We are in our ‘window of tolerance’ if we can both think and feel at the same time
• Babette Rothschild: ‘Eight Keys to Safe Trauma Recovery’
Do you think you need to be able to remember the trauma (‘explicit memory’) in order to be able to recover from it? Why or why not?

Do you view triggers as negatives to be avoided, or as guides to what needs to be integrated?

How can you help a client stay within their ‘window of tolerance’ when working through traumatic memories?
• Moving forwards, we need to do some melting!
  • The freeze in our brains
  • The freeze in our bodies

• Neurogenesis (new cell growth) has been found in the hippocampus
• Stimulated by three things:
  • Exercise (movement)
  • Novelty
  • SSRIs
Session 1.1

• Healing comes through getting back in touch with our bodies
• Dissociation is ‘I’m not here, I’m not in my body’
• Grounding is getting back in our bodies

Session 9

• Successful trauma work includes:
  • Being ‘here-and-now’ present in your body
  • Using that as an anchor to ‘time-travel’ to the ‘there-and-then’
  • Owning and feeling your experiences
  • Distinguishing ‘Faa’ and ‘Baa’
  • Marking trauma memories as ‘over’
SESSION 9

• Powerlessness is normal, but unless we tackle it, everything else will seem impossible

• I refuse to be bowed by the enormity of our trauma

• I refuse to believe the ‘myth of specialness’
Do you believe that we can recover from trauma? To what extent? What is it dependent on?

What needs to be present in the therapeutic relationship to help the client overcome traumatic powerlessness?

What do you need to do differently (if anything) as a result of this course?