Frontiers in the Treatment of Trauma

How to Work with the Part of Trauma That Can't Be Verbalized

the Main Session with

Peter Levine, PhD and Ruth Buczynski, PhD

National Institute for the Clinical Application of Behavioral Medicine

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Frontiers in the Treatment of Trauma: Peter Levine, PhD

How to Work with the Part of Trauma That Can't Be Verbalized

Dr. Buczynski: Hello everyone and welcome.

I am Dr. Ruth Buczynski, a licensed psychologist in the State of Connecticut and the President of the *National Institute for the Clinical Application of Behavioral Medicine.*

I'm so glad that you are here with us.

Our guest today is Dr. Peter Levine. A lot of us follow his work, especially in trauma. He has done some groundbreaking work.

First of all, he has synthesized and built on some of the thinkers that might be his predecessors or perhaps his intellectual ancestors.

In fact, maybe we can talk a little bit about that – some of those ancestral figures as we go along.

So, Peter, welcome – I'm awfully glad you're here.

Dr. Levine: Thanks – it's good to be here! It's been a while.

Dr. Buczynski: Yes, it has. Let's start with one of the ancestors that you noted in your book – and let me just show you some of Peter's books before we go on.

Waking the Tiger was one of the first ones that people started thinking, "Wow – these are different ideas and we have to pay attention to this new set of concepts."

In addition to that one, he's also written, *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness"* – so, take a look at that as well.

Dr. Levine: That book is really my major work.

A Review of the Treatment of Trauma

Dr. Buczynski: Peter, one of the things I noticed is that you credit several people but one of them was Wilhelm Reich. I follow Wilhelm Reich's work a bit, too, and I was curious and excited about that.

Tell us what got you started thinking about him and why his ideas are important to our thinking about the treatment of trauma.

Dr. Levine: Yes, he is really the person who brought the body into psychiatry.

He's certainly not the person, whose methods have been most influential, but he's certainly the giant on whose shoulders body-oriented psychotherapy or emotional work stands on, and methods and psychotherapy are related.

> "Researchers were working with the cultivation of the body's experience and the importance of therapeutic change in the alive body."

There were many other people who were working around the same time – some before but a number after. Reich stimulated a whole series of thought among people like Gerda Boyesen, Magda Proskauer, Lillimoor Johnson in Norway, Charlotte Selver, and many, many others.

These researchers, in different ways, were working with the cultivation of the body's experience and the importance of therapeutic change in the alive body.

There really is a rich tradition – and actually a colleague of mine just recently wrote a book called *Body Psychotherapy* – this is an encyclopedia, many hundred pages, tracing this very rich, vibrant history.

Dr. Buczynski: He also influenced Alexander Lowen with biogenetics, and Fritz Perls, with Gestalt therapy – I have studied extensively Gestalt therapy and Perls referenced him quite a few times.

Neither Lowen nor Perls focused specifically on trauma, but their ideas have influenced some of the ways people who look at trauma think about the body and the experiencing, rather than just focusing on the conversation – the dialogue part.

> "Their ideas have influenced some of the ways people think about the body and the experiencing, rather than just focusing on the conversation."

Dr. Levine: Yes. Reich's work clinically had a lot to do with emotional release – and that was certainly the direction that Lowen took and furthered although he added important concepts.

For example, one of those concepts was grounding, but it really had to do

with emotional release. That may have been applicable for general therapy, but trauma is a very different beast. We can think of trauma as the beast that is.

"The emphasis wasn't on emotional release per se, but on how we embody our conflicts."

Then Fritz Perls took these ideas into a little bit of a different direction. The emphasis wasn't on emotional *release* per se, but on how we embody our conflicts – how we embody different parts of ourselves, such as the critical judge, the underdog, and the upper dog.

He took trauma in a direction that was building more on awareness and less on emotional expression.

Staying with Awareness and Building Aliveness

Dr. Buczynski: In building aliveness as you were saying Perls had the awareness expression cycle and as you stay with what you are aware of, excitement builds.

If you stay with that, you move into action and complete the Gestalt – and that is an important thought. Very often we would focus on something a patient was doing and just say, "Stay with that and tell me more about that."

"Definitely critical is the movement towards excitement and vitality."

Also Fritz Perls had the *Empty Chair Technique*, which was another approach. Very often you would be saying, "Put your backache or the problem in the chair and see what it wants to say."

Dr. Levine: Right – it is a way to separate out the issue physically so you could really look at it and address it.

One thing you said which is critical – definitely critical in my work – is the movement towards excitement and vitality.

"The *vitality affect* means to come back into aliveness and to know the aliveness."

I like to think of that as the *vitality affect* – it is not an emotion, but it is really a core movement that people make as they are healing either emotional wounds or traumatic injury. It really means to come back into aliveness and to *know* the aliveness.

Most people, unless they've had some kind of encounter with their inner forces, really don't think about or don't really attend to the feeling of aliveness, and they certainly don't have that directing the movement of their lives in relationship or in work.

Wilhelm Reich said something, which has always stayed with me: "Love, work, and understanding should be the wellsprings of our life. They should also govern it."

That wellspring comes from excitement, from passion; and from this inner fury to connect and to make a difference.

Dr. Buczynski: As we go on, I'm curious about aliveness. You said that was a really important part of your work and I'm curious about that. Maybe it would be important for us to understand that more fully.

You also studied with – and I'm going to pronounce this incorrectly probably – Paul Ivan Yakovlev – and "study" might not be exactly right, but you went all the way across the country to visit him.

He had some important concepts that really fit with the beginnings of what you were developing.

Dr. Levine: Yes. This is a name that is not well known. As a matter of fact, I would imagine that almost nobody knows of him.

"Trauma is something that happens deep in the core of our brain and our body."

When I finished my doctoral work, I made a pilgrimage to people who had contributed to me as intellectual mentors and were still alive. I visited Raymond Dart, I visited Yakovlev, MacLean, and Curt Richter, John Tompkins, and Yakovlev.

Of course, at the time, there wasn't a word for "bottom-up/top-down" – but I was realizing that our thoughts and even our emotions, when we were working with trauma, really weren't central. Trauma is something that happens deep in the core of our brain and our body.

Paul Yakovlev was an American, but Russian-born neuroanatomist, and when I visited his lab, he just grabbed my arm and excitedly took me around and showed me hundreds and thousands of bottles of sliced brains.

Basically, what he discovered anatomically and what MacLean studied more behaviorally, how we think – the cerebral cortex being in command of what is going on.

"If you look at the brainstem, other parts of the brain are neuroanatomical elaborations of this most primitive part."

We think about things and, of course, that can cause emotions and cause us to be frightened. But he realized that if you look at the brainstem, the center part of the brain, other parts of the brain are neuroanatomical elaborations of this most primitive part.

Even our refined thoughts were elaborations; they were different iterations or the emergence of our basic

instincts – and that's the brainstem, the reptilian brain. MacLean coined the term "reptilian brain." This really was the study – the matrix upon which all experience was built according to Yakovlev.

Dr. Buczynski: Yes – and after that did you visit, in the same trip, Paul MacLean? That must have been a heck of a trip!

Dr. Levine: It was unbelievable! When I left Paul Yakovlev's laboratory – regrettably; I would have been happy to spend a week there with him.

He drew with colored pencils and anatomical precision exactly how I would get out of there, including going through the parking lot of the supermarket and finding my way out to Paul MacLean's lab, which was about fifty miles outside of the city of Maryland.

There was a bit of a difference between Yakovlev and MacLean. As I said, when I saw Yakovlev, he grabbed my arm and just exuded warmth. He was *very,* very excited, and he was equally excited about what I was working on and why I had come to see him.

But when I got to MacLean's lab and I announced myself, he said, "Oh, yes, yes, I received your letter" – and this was way before emails – "What can I do for you?"

I told him about my interests and he looked at me – I've never been able to quite figure out what was going on in his mind – but he looked like a concerned parent as he said, "Oh, that's very interesting – but how are you going to make a living with that?"

Separating Out the Triune Brain

Dr. Levine: Then we proceeded to talk about his triune brain theory, which, again, in many ways is built on Yakovlev's neuroanatomical understanding.

Basically, we have three brains – really we have to consider at least four brains – but based on the triune brain, each of these brains serves a very different function.

These brains are anatomically and neurochemically different, but they do connect with each other. It is this connecting that is at least as important as the differences.

"Basically, we have three brains – each serves a very different function."

He had this core that Yakovlev described, the upper brainstem including the cerebellum and the thalamus – and this he termed the "reptilian brain."

There was the next brain, which we now call the "emotional brain" after Joseph Ledoux – he called this the paleomammalian or the limbic brain based on some earlier studies.

Then we had the cerebral cortex that involves all of our refined perception – vision, motor, sensory – the prefrontal part of the brain.

"It is this unifying of the different parts of the brain that is one of the most important keys in transformative therapy."

This brain is involved in our whole "higher consciousness," which I put in quotes because it's even a mistake to say that this is our "higher consciousness" and this is our "lower consciousness." Each is a different *type* of consciousness, a different *type* of awareness.

Again, to be fully human – to be whole – we have to hold together these powerful instincts and emotions at the same time that we're observing them, reflecting on them, and utilizing them for change.

It is this *unifying* of the different parts of the brain that is one of the most important keys in transformative therapy.

Steps for Treating Trauma

Dr. Buczynski: You illustrated that just a bit – not entirely in therapy but in terms of speaking to the parts of the brain when you talked about the case of Elián González.

Elián González was the Cuban boy whose mother died as they arrived in Florida, and there were a lot of people thinking that we should keep him here. The Supreme Court said that we should send him home.

But you were talking about what the agent said to him and how she approached him.

Dr. Levine: Yes. I don't remember exactly, but I have the picture in my mind – it is one of these pictures you want to hold with you.

I believe she was an FBI agent and literally, there were people yelling and screaming. They had placards. If they could, they would have pulled him apart – one group pulled his arm and leg in one direction and

another group pulled in another direction. It was like in the Caucasian Chalk Circle or in the Bible – they were just tearing this child apart.

> "When a person is traumatized, almost nothing feels safe."

And this agent – I believe she had been coached by a child psychologist.

Dr. Buczynski: Here is what she said – "Elián, this may seem scary to you right now, but it will soon be better. We're taking you to see your papa. You will not be taken back to Cuba" – which was true for the time being, you said. "You will not be put on a boat again" – he had had that treacherous boat accident.

Dr. Levine: Right – they almost drowned.

Dr. Buczynski: "You are with people who care for you and will take care of you."

Dr. Levine: Yes. Thank you for reminding me. What she did is something that every trauma therapist has to do – and that's not only working with kids.

First of all, it's important that a person in trauma be able to get a sense that something has a beginning, middle and end – that there *is* an end.

Even *more* important is that you feel *safe* – that somebody is going to be there at your side, is going to take care of you, and that you will be reunited, and in Elian's case, with his father. Actually, the father was in Cuba and the relatives were here.

> "It's important to help the client learn tools that they can use to help them feel relatively safe."

You could see Elian in her arms, just let go. When a person is traumatized, almost nothing feels safe.

As therapists, we want to be able to convey, at least in the smallest amount, an island of safety – that there is a way to feel safe. Something has happened to you and you survived it.

Now, we're going to go back and I'm going to pick up some of those pieces that you left behind, so you can be whole again.

The other thing that is important in trauma therapy is that, as soon as possible, the therapist needs to provide tools.

It's important to help the client learn tools that *they* can use to help them feel relatively safe.

If the only place they feel safe is with you, the therapist, then when they leave and they again start feeling horrible, terrified, helpless, very frequently they'll shame themselves into what Fritz Perls called "the top dog." They'll feel completely dependent on the therapist.

We can help if we can give them even the smallest tools for self-soothing, for self-regulation.

Dr. Buczynski: Can you mention one right now?

Dr. Levine: Here is one that I just did in a case consultation – I often demonstrate a number of these with a client.

I don't know if you can see this – I might move back a little bit – but here is what you do.

"When we can feel our body as the container, then the emotions and the sensations do not feel as overwhelming – they're being contained."

Take your right hand and put it here, under your left arm on the side of the heart. Yes – got it. Put the other hand on the shoulder. This is just to get the feeling, Ruth and for everybody else who is watching – of what this sensation is like, not just of your hands but of what is going on inside of your body.

Dr. Buczynski: As you watch Peter talking right now and as you listen, give this a try yourself so you know what he's talking about.

Dr. Levine: Yes – please, I invite you. Most people report a settling. This helps us become aware of our *container*.

We'll probably get into this a little bit more, but the body is the container of all our sensations and feelings – it's all in our body.

Yet the container of the body is the outside of our body – our shoulders, the sides of our thorax. When we can feel our body as the container, then the emotions and the sensations do not feel as overwhelming – they're being contained.

I usually suggest people do the one I just described first, and then another very simple tool for them to do – a second one – is to put their hand on their forehead and the other hand on their upper chest, and then wait.

They can do this with their eyes open or closed – whatever they feel more comfortable with. A lot of people like to do it with their eyes closed; others don't feel safe enough.

This is a way to just feel what goes on between the hands and the body.

"I just ask them to keep their hands there until they feel some kind of a shift."

Sometimes they will feel an energy flow, or a change in temperature. I just ask them to keep their hands there – it could be just a few moments or it could be five or ten minutes – they keep their hands there until they feel some kind of a shift.

Then I have them take the upper hand here – keep the lower hand on the chest – and put this hand on the belly. Again, I ask them just to wait until there's some shift – till there's some flow.

Sometimes, if people are unable to sleep or they're afraid they're going to have nightmares, they can do simple positions like this. They fall into sleep much better, and often their dreams are much more useful.

There are other techniques – the tapping, the energy psychology approaches – and for some people those work very well.

"Through tapping, you can help the body to remember that it is the container."

Another thing I suggest is literally tapping the skin all over so they get a sense of the boundary. For people who are traumatized, there is a hole in their boundary.

Through tapping, you can help the body to remember that it is the container, and then they feel more able to deal with their sensations and their emotions.

Squeezing the muscles in different parts of the body also helps with getting that sense of boundary.

Body Signals to Guide Action after Trauma

Dr. Buczynski: Peter, it should be evident now that you're focusing on or finding that the body is critical in treatment. It's an important part of the psychotherapy or a way of looking at the whole person.

I noticed that you said the body gives signals to guide action after a traumatic event. There are signals for helplessness or paralysis. Can you tell us more about that?

Dr. Levine: When I first started to study trauma, at least eleven or twelve years before the formal definition of PTSD, there was no word for it at the time.

But I noticed, as I worked with clients and was developing a mind-body approach in the sixties and seventies,

that many of their symptoms seemed to trace to different events in their lives – many to their childhood as well as to their adult lives.

"We do all kinds of things to defend and protect ourselves – the body does this instinctively and innately."

When trauma became formalized – in the DSM3 I guess – it was more about the brain with symptoms like flashbacks, hypervigilance, the inability to sleep, and dreams.

But what I was discovering before that is that trauma also happens in the body.

For example, just think about what happens if you walk into a room and there's something horrible, "Agh!" Your eyes open, you take a deep breath, and you hold the breath. When that becomes chronic, then the body is in dysfunction.

During the Bosnian-Serbian war, I remember seeing these older women coming to the street and starting to cross, and then they would get part way across the street and a bomb would go off or bullets would be raining down on them.

You would see their shoulders go up and they would run back, and they would be able to let go of their shoulders. Then, they'd try to cross again, and there would be an explosion and their shoulders would go up – then they'd come down.

The third time there was an explosion, the shoulders went up and the shoulders stayed up.

We do all kinds of things to defend and protect ourselves – the *body* does this instinctively and innately.

It is not something we figure out – these women didn't think, "Uh-oh, I just heard a bomb – I'd better protect myself by moving my shoulders up." These are reflexes. They are instinctual.

In trauma, our body gets stuck in either preparing for defense – for mobilization, or for immobilization – shutdown and collapse, which is associated with feelings of utter helplessness.

I discovered that until these experiences in the body are changed, the person continues to feel helpless, hyperaroused, and hypervigilant.

But when they changed in the body – and I'm talking not just about the muscles but also the autonomic nervous system – then the trauma wasn't there.

"In trauma, our body gets stuck in either preparing for defense – for mobilization, or for immobilization – shutdown and collapse."

You can think of it this way: "Here is the trauma – Where is the trauma?" As people have new experiences, as I said before, to contradict those of helplessness, collapse, fright, and freezing, they move toward agency, empowerment, vitality, excitement, and goodness!

"If we're just exposing the person to the trauma without fundamentally changing the experience, then our work is not done."

I debated over and over whether I should use that in the title of the book, in *An Unspoken Voice* – how the body releases trauma and restores goodness.

Goodness is really the key here. If we're just exposing the person to the trauma or trying to think about it in a different way without fundamentally changing the experience, then our work is not done – we haven't gotten to the full resolution.

Mapping the Body

Dr. Buczynski: When you're thinking about trauma, one of the things you say that therapists or practitioners need to do is to map the body.

Briefly, what do you mean by that, and then we'll tie it into the next thing I'm going to ask you about.

Dr. Levine: Two people are sitting – let's just say they're facing each other or partly facing each other. It is not like psychoanalysis where the patient is lying on the couch.

When you sit with another human being – whether you want to do this or whether you're even aware that you're doing it – you're sharing a lot of sensations and feelings.

"When you sit with another human being you're sharing a lot of sensations and feelings."

Whatever feeling and sensation we have, the other person is resonating to that in a certain way, and of course, the research now shows a clear neuroscientific basis of that with the idea of the mirror neurons.

But I think it's much more complicated than that. Our whole organism is wired, from birth, to co-participate, as Daniel Stern says, in each other's *affective internal life*.

We're getting a lot of information from the client. We're getting a lot of information from what we're observing, even though we may not be aware that we are observing it.

We're also getting information from our own sensations. The person that we're in therapeutic relationship with is also having an internal experience and they're observing us.

So basically, I divide this experiencing into two categories. Even though we can resonate, we don't *really* know what a person is experiencing.

> "Even though we can resonate, we don't really know what a person is experiencing."

It probably has to do with our own history and our own experience, but basically, we don't know what another person is experiencing, not in a precise enough way.

But we can observe certain things. We observe facial expression – Paul Ekman has done a lot of really wonderful work with that. I had an opportunity to spend some time with him in San Francisco a week ago.

He, for example, trains people to see what he calls *microexpression*, which is a moment of fear or a moment of anger or a moment of disgust that comes in a couple of hundred milliseconds – and then it's gone.

He finds that it's very easy to train people to observe that because we're already doing it – we're just not aware of it. So he helps people to bring that into awareness.

But that's only part of it. The emotions – the *sensations* – are even more central, more important.

We, of course, also observe gestures, and the types of postures important to notice are called *micropostures* – very small amounts of shifting into a collapse.

I'm illustrating that a little bit here. Now I'll exaggerate it. We can observe an elongation of the spine. Here we look at a, very slightly, a shoulder going up.

I developed a map, which I call SIBAM. S means the *sensations* that the client is experiencing – the body sensations – and they fall into several different categories.

By the way, when I say "sensations," I am talking about internal sensations – not what we see, hear, or smell, but sensations that are originating *originally* from the body. This is muscle tension or relaxation – or collapse.

> "Microexpression is a moment of fear, anger, or disgust that comes in a couple of hundred milliseconds—and then it's gone."

Dr. Buczynski: Is this what we're tracking in the patient or are we tracking it within ourselves as we listen to the patient?

Dr. Levine: No, we're helping the patient track that in their own bodies.

They become aware of and give attention to areas of expansion and collapse of the muscles.

There's also proprioception – and I'll give you an example. I'm closing my eyes here. I hope I can do this but I start conducting this orchestra and then I put my finger right on the tip of my nose. How do we do that? If you think about it, that is miraculous.

So, we're talking about a combination of muscle tension information coming up into our brainstem – the cerebral cortex doesn't do this; the position of our joints also relates to the brainstem and gives us information.

"We also have sensations that have to do with blood flow and sensations that are coming from our internal organs."

We also have sensations that have to do with blood flow and sensations that are coming from our internal organs – the organs that are in our chest and our belly. The work of Stephen Porges, a dear friend, has amplified this very, very important work in what he calls his polyvagal theory.

We have reference, through hundreds and hundreds of thousands of fibers that are going from our gut and from our heart – the viscera – into our brains. Again, that is another part of the sensation.

Next, we have the I of SIBAM which means *image*. This can be a little bit confusing and counterintuitive, but I thought about this over many years and finally realized that this is the best way to describe it.

So, we have the *images* and these are not only visual images, but can be sound, taste, smell, and touch. These are *images* that originally come from the outside and are stored in the person's brain and the body.

"Images originally come from the outside and are stored in the person's brain and the body."

Then B refers to *behaviors*. Actually, *behavior* is the one thing that the therapist is observing and the client also can observe as they become aware of their body sensations.

Behavior is the primary inlet the therapist has – if the therapist just goes on what the client is feeling – the therapist can get into problems with that because sometimes what people are feeling is not what they're *ready* to become aware of.

"*Behavior* is the primary inlet the therapist has."

But the therapist is able to track the behaviors. There are voluntary expressions. For example, you might have a politician saying, "Oh, I'm so glad; my heart is so warm to be here in the state of – what state are we in? Oh, yes, Minnesota – right!" That's a gesture meant to convey an emotion, but it's not really an emotion – it's a voluntary gesture.

We have facial expressions – that is behavior, and there are different kinds of emotional expressions. We have postures and breathing, which, again, the therapist can observe, notice changes, and *use* that information at the right time to bring the client into their inner landscape – their inner experience.

"The therapist can observe, notice changes, and use that information at the right time to bring the client into their inner landscape – their inner experience."

We have postural and visceral behaviors – sometimes you'll hear gurgling and other internal sounds. Or you'll see blood-flow changes as the color of the person's hands or their face will be changing. Those are behaviors that go deeper and deeper.

A behavior that is very important and almost always overlooked is what I call archetypal expressions.

You'll be working with a client and all of a sudden the hand will do something like this or like that I was going to graduate school at Berkeley and I started to notice these kinds of gestures in clients. I happened to go to a dance performance – I think it was from Thailand – and I couldn't believe it: in their dances – their hands – were making these same kinds of expressions that I was observing in my clients.

When clients became aware of this, it became a very powerful resource – it was what you could call transpersonal. It didn't just have to do with the person – the dance does not just have to do with the person. The dance is something that is universal. So those are the different kinds of behaviors that the therapist could observe.

"A behavior that is very important and almost always overlooked is archetypal expressions."

Then A of SIBAM means *affects*. Basically, the *affects* are divided into two categories. One are the primary emotions, as originally described by Darwin – anger, fear, sadness, startled, joy and disgust.

Often you see those through microexpressions in the face – through that emotion being there for two hundred milliseconds. The person is talking about, "Oh, yes, everything's going well. I'm really enjoying my job" and you the therapist can see the microexpression of disgust. That behavior gives you information to use as well.

The *most* important *affects* – and somebody once called them "contours of feeling" – are the ones, for example, when you go to an art museum and you see beautiful works and we are touched, or you're walking out and seeing the morning dew on a blade of grass.

"Contours of feeling" just fill you with goodness and contentment – and that can happen with just a little

bead of water!

These "contours of feeling" – or "felt-sense nuances" – a term coined by Eugene Gendlin – are really much more important for our well-being.

"The emotions come and go – but 'felt feelings' – 'contours of feeling,' are what really take us through a day."

The emotions come and go – but "felt feelings" – "contours of feeling," are what really take us through a day. You can imagine having a day where you don't have a strong emotion – where you're not angry or fearful or disgusted.

But it's really hard to imagine going through a day where you don't have these softer feelings, the nuanced feelings that really guide us. They're our rudders through life.

"The person moves through these cycles of *sensations*, *images*, and *affects*, and they come to new *meanings*."

Then M is *meaning*. That is what I often refer to in cognitive behavior therapy as the thoughts – basically the beliefs.

When a person is stuck in trauma, the *meanings* are what they get from their body experiences: "The world is a dangerous place. I have no energy. Nobody is going to help me. I will always be helpless." These are the thoughts that match these inner sentient experiences.

But then what happens – and this is really the poetry – the person moves through these cycles of *sensations*, *images*, and *affects,* and they come to new *meanings*.

Let me give an example. This is a woman I work with. Her name is Jody. She's in her early twenties and was visiting her now husband in New England. It was autumn and she went for a walk in the woods.

She came across this hunter – a man with a rifle – and she started a conversation with him. He took his gun, lifted it up, and hit her on the head. She fell to the ground and he kept banging and hitting her head until the stock of the gun broke. The boyfriend heard him doing that but thought – it was autumn – somebody was chopping wood.

"What we're doing is the opposite: 'Let's see what is really *making* that movement.'"

You can imagine the symptoms that she had. One of the things that we discovered was this micro-movement where her head wanted to go like this – and, again, I have to do this very slowly. This is the key: you don't make that a voluntary movement.

That's the difference between this and Gestalt – there we say, "Make that response. Amplify this." What

"Many traumatized people think that if they can remember the trauma, then somehow it will be released."

we're doing in a way is the opposite: "Let's see what's underneath that. Let's see what is really *making* that movement."

She felt this and she got to this place – you could see her eyes open wide: "Okay, now that's it. Now come back a little bit and just feel that edge." In the session before that, she was struggling, trying to remember.

Many traumatized people think that if they can remember the trauma, then somehow it will be released – and that is not true, but that was the first thing that she was struggling with when we came in.

When I was able to say, "Okay, we can come back to what happened, but instead of trying to remember – actually you don't *need* to do that – you don't need to remember to heal." That gave her tremendous relief.

She came in the next day and you could see she was completely different. She had energy and she had color in her face, and she said, "You know, after the session, I was staying by the river" – there was a little motel near where I practiced in Colorado – "and I realized then when I moved there" – and she had severe TMJ temporomandibular joint disorder and depression – "that is when I must have passed out.

That is when he must have hit me for the first time. I did that for a little while and then I realized, 'This is my ear." She was also having hearing problems "my ears, my tears and my fears.'" This was the new meaning.

It's this kind of poetry that you don't expect and it's always something of wonder – both for the client and for the therapist. I hope I didn't go into too much detail here.

Dr. Buczynski: No – in fact that's pretty interesting. What did you do after that?

Dr. Levine: We went through several sessions where she could feel – at the first session she felt her body trembling a little bit and that was very disturbing for her so I wanted to guide her away from that.

But then as we did some further sessions, her whole body started to shake with waves of trembling – cold, heat, and sweat occurred. Then in one of those sessions, she was able to close her eyes and to just allow the trembling – and she had an *image* – because they lived in Aspen, Colorado – of the quaking aspens.

She could connect, again, with this *image* of nature to relate to her shaking and trembling, which helped to reset her nervous system.

"She could connect with this image of nature to relate to her shaking and trembling, which helped to reset her nervous system."

Over a two to three-year period, about twenty-two/twenty-four sessions, we worked together on this and she's doing beautifully. I had a wonderful surprise – I actually worked with her daughter.

Her daughter was born with necrotizing enterocolitis. Right at birth, they had to do surgery on her intestine. Jody had some guilt about whether it was her trauma that got passed on. At the same time that I did some work with her daughter – she was about nine or ten at the time – I also worked with her son. They both turned out to be world champion skiers.

Two years ago I received the Award of the United States Association for Body Psychotherapy and this really very alive, vibrant young woman came up to me it was the daughter! She said, "I just wanted to let you know, I just completed the training program." It was a nice ending.

The Bottom-Up vs. the Top-Down View of Emotions

Dr. Buczynski: Interesting. You have some ideas about different ways to look at emotion, and you call it the "Bottom-up versus the top-down approach" view of emotions." Can we get into that a little bit?

Dr. Levine: Sure! Actually, we have to go back to the turn of the century – the last century, not this one but the one before – to William James.

At that time, the basic philosophically oriented, Cartesian-oriented idea was you see a bear and you think, "Ooh – bad news. That bear could kill me." Then those thoughts cause you to have the emotion of fear and the fear makes you want to run away from the bear – definitely not a good idea to do.

William James said that that is incorrect. He said, "We don't run away from a bear because we are afraid – but rather, we're afraid because we're running away from the bear." That is to say – and this is the part where he was correct – what goes on in our *bodies* is the basis of our emotion.

> "What goes on in our bodies is the basis of our emotion."

What I say – and he came very close to getting it right – is this: it is not that we're afraid because we're running – if we're running, and it is free running and we escape, we don't experience fear, we experience running.

We see animals evading predation – they run and after they have escaped, they don't really have any bodily signs of fear. They may be out of breath for a little bit, but they go right back to what they were doing before.

It's not that we're afraid because we run, but we're afraid because we have the impulse to run, and we cannot execute it or execute it fully, or we're thwarted by somebody chasing and grabbing us – it could be a rape or a mugging, but the fear is not because we ran, it's because we actually *couldn't* run, but we prepared to run.

"It's not that we're afraid because we run, but we're afraid because we have the impulse to run, and we cannot execute it or execute it fully."

This is the difference. The emotions come as Darwin proposed. They come automatically, but in Darwin's time, there was not the understanding of what happens in *trauma* with the emotions. Is that clear or should I try to say that in a different way?

When we work with people – and this is important – therapeutically, in some of the older expressive therapies, the emphasis was on, "You're angered. Get the anger out. Get it out. Get it out. Hit the pillow; yell or scream at your mother."

When I was at the Esalen Institute, I noticed that people would come and they would do this in their groups, and they would come back six months later and they would do exactly the same thing.

They felt good – they felt relieved. Again, as I later realized, it was because they were flooding their body with some very high chemicals: adrenaline, catecholamines, as well as endorphins. They felt this wonderful release and also the group bonding, but really the emotions didn't change.

The key that I discovered in changing emotions actually came largely from my study of the work of a woman named Nina Bull, a remarkable woman.

Some years ago – actually when I was getting that award, Stanley Keleman had received it the year before and he was there and we had a chance to talk a little bit. He was also profoundly influenced by this woman.

"It doesn't do you any good to hit because all you can feel is the hitting and the anger is still there."

The idea is that it doesn't do you any good to hit because all you can feel is the hitting and the anger is still there.

But if you can *feel* what your body does to prepare for the anger and the wanting to hit, it's enough to just hold that – because it's the *attitude* and the *impulse* of where the feeling is.

There's a wonderful teaching story that I use in the book. This young samurai warrior goes to this Zen master and he demands of the Zen master, "Is there heaven and hell?"

"We have to change how the emotion is organized and embodied in our organism."

The master looks at him and says, "Wow! How is it possible that somebody as ugly and dumb as you could become a samurai warrior?"

The brash young man takes his sword out of his sheath, holds it up against the master – he's getting ready to slice the Zen master in half – and with equal calm, he looks up and says, "That is hell."

He puts down his sword, puts it in its sheath, has a breath of relief, looks at the Zen master – and the teacher says, "And that is heaven."

That is how we move out of these habitual postures of fear, of anger, of sorrow – and we can *change* the basic way we feel.

But just expressing it over and over doesn't do that. We really have to change how the emotion is organized and embodied in our organism.

Dr. Buczynski: So we want patients to learn to experience the emotions without necessarily physically responding.

"The emotion comes in the readiness and in holding the readiness – not in executing the emotion."

Dr. Levine: Yes and no. Again, the emotion comes in the readiness and in *holding* the readiness – not in executing the emotion.

If you're in anger and you want to hit, you hold it there. You feel that desire to hit – and then you can change how you complete that. It's just taking that moment and saying, "Ah! I feel an openness in my chest. I feel a surge of energy moving."

Actually, the feeling of anger or rage is not a feeling that comes from the gut; it comes from the diaphragmatic area. As you feel this rush of energy and you're able to contain it – you had the little talk before about the body as container – that shifts to vitality and to forward movement.

"Anger moves and then transforms to healthy aggression. Sadness can change to empathy and compassion."

Anger moves and then transforms to healthy aggression. Sadness can change to empathy and compassion. Fear can change to the sense of being able to protect oneself.

All of these emotions have a transformative element – you could also say an alchemical trajectory – once the emotion is accessed, it becomes a life-promoting experience instead of a stuck-emotion experience.

Dr. Buczynski: Peter, we are all out of time and we have covered *so* much ground – not at all the way I planned but in fascinating and exciting ways. I think

Peter, what's next for you? What are you going to study?

Dr. Levine: I don't know, but I've done some pro bono work with Vietnam vets and now Iraq and Afghanistan vets as well.

I've had the privilege to work with some who've been completely destroyed and just unable to function to now seeing these soldiers transformed. So I'm really committed and I am working with some people on trying to bring this kind of work and healing to returning warriors and to help them re-integrate into their families.

Actually, I was just up in LA for a meeting with some people in Hollywood to talk about the possibility of making a TV show based on what these soldiers and families are going through, and how they can – through healing –come back into softening and relationship.

Dr. Buczynski: We'll keep an eye out for that. I just want to say, Peter, thanks for all that you have done.

Thank you for really taking the risk of developing ideas that, before you brought them out, hadn't been the way people were thinking. It has made such a difference – so continue to develop those ideas. Thank you so much.

Dr. Levine: Thank you.

About the speakers . . .



Peter Levine, PhD is the originator and developer of Somatic Experiencing® and the Director of The Somatic Experiencing Trauma Institute. He holds doctorate degrees both in Medical Biophysics and in Psychology. During his thirty five-year study of stress and trauma, Dr. Levine has contributed to a variety of scientific and popular publications.

Dr. Levine was a stress consultant for NASA during the development of the Space Shuttle, and has taught at treatment centers, hospitals and pain clinics throughout the world, as well as at the Hopi Guidance Center in Arizona.

His best selling book, Waking the Tiger: Healing of Trauma, is published in 22 languages. His most recent book is In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness.

Ruth Buczynski, PhD has been combining her commitment to mind/body medicine with a savvy business model since 1989. As the founder and president of the *National Institute for the Clinical Application of Behavioral Medicine*, she's been a leader in bringing innovative training and professional development programs to thousands of health and mental health care practitioners throughout the world.



Ruth has successfully sponsored distance-learning programs, teleseminars, and annual conferences for over 20 years. Now she's expanded into the 'cloud,' where she's developed intelligent and thoughtfully researched webinars that continue to grow exponentially.