

**RE-PATTERNING TRAUMA THE BODY,  
ENERGY SYSTEM AND PTSD**

(Its Physiological Effects and Emotional Symptoms)

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**If it is true that at the core of our traumatized and neglected patients' disorganization is the problem that they cannot analyze what is going on when they re-experience the physical sensations [somatic experiencing] of past trauma, but that these sensations [or somatic experiencing] just produce intense emotions without being able to modulate them, then our therapy needs to consist of helping people stay in their bodies and understand these bodily sensations (Rothschild, 2000).**

Somatic experiencing at the physical sensation and energetic levels can either re-traumatize a person or assist in re-patterning the past and creating new neurological responses, energetic configurations and brain patterns that provide long-term changes verses short-term symptom relief.

Too often healers and therapists in the attempt to assist their clients out of their suffering or pain, reintroduce them in to the same physical symptoms and neurological pathways in a manner that entrenches the trauma. To heal trauma, therapist and healers must learn to help a client re-pattern trauma which changes the energetic structures as well as unhealthy neurological pathways that were created by the trauma. In this authors' private practice, I often see clients who were re-traumatized by various methods designed to heal trauma because the therapist or healer did not understand the basic physiological responses to trauma.

Going too fast, too deep, too soon and/or not providing time to integrate previous work is contraindicated. EMDR and other trauma methods are only as successful as their application.

This paper provides some information on the known physiological responses in the brain and body and outlines the current clinical diagnosis criteria for PTSD. It also outlines some treatment options from **a mind, energy and body (ME-B)** orientation.

This author believes that the root of many other disorders such as anxiety, stress and depressive disorders and some personality disorders are the result of emotional and/or physical trauma that has never been relieved, re-patterned and healed at the mind, energetic and/or body levels. Not addressed, and left in shadow, this trauma can negatively and significantly influence ones sense of self and thus ones ability to create happiness, relationship and a fulfilling life.

Trauma can begin as early as at the point of conception. This author believes the broader diagnosis of “trauma” goes beyond the parameters of the current therapeutic definitions for Post Traumatic Stress Syndrome (PTSD).

### **THE BRAIN AND TRAUMA**

Trauma is a psychophysical experience, even when the traumatic event causes no direct bodily harm. That traumatic events exact a toll on the body as well as the mind is a well-documented and agreed-upon conclusion of the psychiatric community

**Using the ME-B systems is a vital resource in the treatment of trauma.** *Unfortunately, in traditional cognitive therapies this is not explored.* The Mind Energy Body Institute is excited to see dramatic positive

advancements in body centered, somatic trauma therapy. Somatic Experiencing has been named as a phenomenon that happens in relationship to trauma. There are some scientifically supported therapeutic theories and strategies that are widely accepted for making use of the mind-body connection to re-pattern and heal trauma.

This author believes a natural evolution to body centered strategies is to include subtle energetic awareness. Using ME-B orientation (or related body-centered techniques) can mean the difference between long-term healing and simply short-term symptom relief.

Below is a summary of how the brain, nervous systems, mind and body are programmed (through life events and the subsequent physiological responses). Understanding how the brain functions also helps us understand why we have difficulty recovering from trauma and stress.

Research shows that much is still unknown about the details of the brain's response to trauma -- however, what is now understood can be used to benefit clients experiencing the difficult and painful symptoms of PTSD.

Understanding the brain and nervous system's functioning can help explain how the brain and body processes, remembers, and perpetuates trauma and can hold keys to the treatment of the traumatized or stressed body and mind (Rothschild, 2000).

Arousal, and therefore traumatic hyperarousal, is mediated by the limbic system, which is located in the center of the brain between the brain stem

and the cerebral cortex (Rothschild, 2000). The limbic system is closely related to the autonomic nervous system (ANS).

The limbic system evaluates a situation, then signals the ANS to have the body rest or prepare for effort (Rothschild, 2000). The ANS helps regulate smooth muscles and other viscera: the heart, circulatory system, kidneys, lungs, intestines, bladder, bowel, and pupils (Rothschild, 2000).

The ANS has two separate systems that usually work in coordination with one another (Rothschild, 2000).

- Parasympathetic nervous system (PNS) is primarily aroused in states of rest and relaxation.
- Sympathetic nervous system (SNS) is primarily aroused in states of effort and stress, both positive and negative (fight and flight).

The limbic system responds to the extreme of traumatic threat, by releasing hormones that tell the body to prepare for defensive action. Following the perception of threat:

- (1) the amygdala, signals an alarm to the hypothalamus (two Limbic system parts); this then turns on the SNS and the release of corticotropin-releasing hormone (CRH); and those actions continue, each with a separate, but related task (Rothschild, 2000). First, the activation of the SNS will, in turn activate the adrenal glands to release epinephrine and norepinephrine to mobilize the body for fight or flights. This is accomplished by increasing respiration and heart rate to provide more oxygen, sending blood away from the skin to the muscle for quick movement. At the same time, CRH is activating the

pituitary gland to release adrenocortio-tropic hormone (ACTH), which will also activate the adrenal glands, to release a hydrocortisone, cortisol (Rothschild, 2000).

**In a normally functioning system, once the traumatic incident is over and the fight or flight has been successful, the cortisol will halt the alarm reaction, and it will halt the production of epinephrine/norepinephrine (Rothschild, 2000). This helps restore the body to homeostasis and is called the HPA axis. In PTSD, the adrenal glands do not release enough cortisol to halt the alarm reaction.**

Studies show that people with PTSD have lower cortisol levels than controls, even those with other emotional problems like depression (Rothschild, 2000). Whether this is a purely biological process or is influenced by perception in the limbic system is not known (Rothschild, 2000). While lower cortisol levels are documented in PTSD, their cause is still a question.

In the book, *Waking The Tiger*, Peter Levine explains this physiological response in terms of our more primal beginnings.

“The involuntary and instinctual portions of the human brain and nervous system are virtually identical to those of other mammals and even reptiles. Our brain, often called the triune brain, consists of three integral systems (Levine, 1997). The three parts are commonly known as the reptilian brain (instinctual), the mammalian or limbic brain (emotional), and the human brain or neo-cortex (rational). Since the parts of the brain that are activated

by a perceived life-threatening situation are the parts we share with animals, much can be learned by studying how certain animals, like the impala, avoid traumatization,” (Levine, 17, 1997).

Levin explains that traumatic symptoms are not caused by the triggering event but by the frozen residue of energy that has not been resolved so it remains trapped in our nervous system where it can, “wreak havoc on our bodies and spirits,” (Levine, 19, 1997). Levine writes that animal’s brains don’t override the natural instinctual response to trauma and thus usually don’t suffer long-term effects. Levine says there are three primary responses available to reptiles and mammals when faced with an overwhelming threat:

- (1) immobility or freezing,
- (2) fight and
- (3) flight (Levine, 1997).

For instance, an impala, being chased by a cheetah, at the moment of contact (or just before) falls to the ground, surrendering to its impending death (Levine, 1997). Yet, it may be uninjured. The stone-still animal is not pretending to be dead (Levine, 1997). It has instinctively entered an altered and painless state when death appears imminent. Many indigenous people view this as a surrender to spirit and physiologists call this state the immobility or freezing response (Levine, 1997). If the impala does not die, it will literally shake off the residual effects of the immobility response and gain full control of its body (Levine, 1997). It will then return to its normal life as if nothing had happened. Levin writes, “physiological evidence clearly shows that the ability to go into and come out of this natural response is the key to avoiding the debilitating effects of trauma. It is a gift to us

from the wild,” (Levine, 17, 1997). He goes on to explain that humans, unlike animals, don’t (or can’t) try to fight or flee when threatened (Levine, 1997).

**Our human brains often second guess our innate instincts of fight, flight and our ability to shake off our freeze response. This then can cause emotional or physical trauma to be trapped in our minds and our bodies because our nervous system malfunctions.**

“As surely as we hear the blood in our ears, the echoes of a million midnight shrieks of monkeys, whose last sight of the world was the eyes of a panther, have their traces in our nervous systems,” (Levine, 17, 1997). – Paul Shepard

It is believed that if an infant’s brain growth process receives trauma early in life or before birth, it negatively influences the brain and the nervous system’s ability to process stress and trauma because the brain’s organization is flexible and subject to influence (Rothschild, 2000). Prenatal trauma and interaction between baby and caretaker determines normal brain and nervous system development (Rothschild, 2000). Well-cared-for babies become adults with more resilience – on the other hand, babies raised by caregivers unable to meet significant portions of their needs are at risk of growing into adults who lack resilience and have trouble adapting to life’s cycles and are more likely to suffer from PTSD (Rothschild, 2000).



All of the information coming into the body and brain through the senses is realized and registered through discrete sets of synapses -- each reflex, behavior and emotion (Rothschild, 2000). The brain regulates these synapses and the body reports back to the brain through synapses creating communication from body to brain and brain to body (Rothschild, 2000). It is also through synapses that thoughts are linked as concepts or specific events (memory). Cognitive memory involves linking nerves via synapses with the brain and then recorded within the brain (Rothschild, 2000).

During stress and trauma, this relay of information is often disturbed. Rothschild feels that healthy brain and neurological maturation positively influences someone's ability to recover from trauma and stress (Rothschild, 2000). In turn, how the brain processes and remembers traumatic incidents will determine who may and who may not develop PTSD (Rothschild, 2000). A healthy brain and nervous system free of prenatal and infant trauma, is less likely to develop PTSD should later trauma occur. **In addition, it might be true that once the nervous system has developed unhealthy patterns, it becomes easier to become stressed or traumatized by events that normally would not appear to be traumatic.** (This author wonders if that is why panic attacks can be triggered by seemingly everyday events.)

If a client with PTSD connects to body sensations or somatic memory and eventually links it to our cognitive system or our cognitive memory-- the re-patterning of PTSD (trauma and stress) and the unhealthy nervous system is possible (Rothschild, 2000). It is not always necessary to link a somatic memory or body sensation to the cognitive memory in order to shift

symptoms of trauma or stress. Sometimes just going with the body sensations is enough to shift trauma in the short-term. Eventually all ME-B systems can be brought on board for deeper healing.

This author believes that when our body does produce negative reactions such as (anger, lack of sleep, anxiety, disconnection, panic...) feeling the relationship of the symptom to the physical sensations or disturbing thoughts or memories – helps re-pattern the trauma or stress and eliminate or reduce the symptoms and positively reprogram our brain and nervous system. It is essential that this process is done slowly and gently or else the reverse effect can transpire, reinforcing the unhealthy mind-body pattern instead of relieving the unhealthy pattern.

Therefore, the same “energies” that create the symptoms of trauma and stress, when properly engaged and mobilized, can transform the trauma and propel us into new heights of healing, mastery, and even wisdom (Levine, 1997). Levine writes, “having spent the last twenty-five years working with people who have been traumatized in almost every conceivable fashion, I believe that we humans have the innate capacity to heal not only ourselves, but our world, from the debilitating effects of trauma,” (Levine, 21, 1997).

Levine supports a broad definition of trauma, many of which are in the DSM-IV under PTSD (Levine, 1997). He doesn't claim that trauma is the only cause of these symptoms, but he does feel that trauma plays a major role. He is also clear in stating that not everyone who feels trauma, has these symptoms.

According to Levine, early, middle and late symptoms of trauma:

- Hyperarousal
- Constriction
- Dissociation or denial
- Feelings of helplessness
- hypervigilance
- intrusive imagery or flashbacks
- extreme sensitivity to light and sound
- hyperactivity
- exaggerated emotional and startle responses
- nightmares and night terrors
- abrupt mood swings, and
- reduced ability to deal with stress
- difficulty sleeping
- .panic attacks
- anxiety and phobias
- mental blankness
- fear of dying, going crazy or having a shortened life
- shame
- difficulty sleeping
- exaggerated or diminished sexual activities
- amnesia and forgetfulness
- inability to love, nurture, or bond
- inability to make commitments
- chronic fatigue
- immune problems
- psychosomatic illnesses

- depressing
- feelings of detachment, alienation and isolation
- frequent crying, and abrupt mood swings (Levine, 17, 1997).

(since the original writing of this paper, much more has come to light about the brain and trauma. I recommend contacting [www.sensorimotorpsychotherapy.org](http://www.sensorimotorpsychotherapy.org) and reading their book, *Trauma and the Body*.

## **TREATMENT**

There are many different treatments for trauma such as regressive therapies, behavior and cognitive therapies, EMDR or energetic and mind-body therapies. Based on the research in this paper that suggests that trauma and stress is held in the body as well as the mind, this author believes that body psychotherapy is a very positive method to deal with physical and emotional trauma. Whatever the method of therapy used, the importance of gentle re-patterning of the body's nervous system seems key (Rothschild, 2000).

This author believes that every human holds some trauma. It does not matter if the trauma is linked to an actual event such as an emotional incident or a physical event. It does not matter if an actual event or a series of actions produces the trauma – the process of recovering and re-patterning the trauma includes the following key factors.

- (1) Be careful not to re-traumatize a client during the healing process. At a minimum, this means that the client should be able to identify a “safe place” within them that they can call into vision and sensations within their mind and body. If the trauma become too intense, then

the client can call in their “safe place” to help re-center them. In addition to the “safe place”, clients can also come up with some sort of containment of trauma that may still be present when the session concludes. They can visualize a trashcan or hole or whatever works for the client. Clients can put any trauma still holding in their ME-B system into this container to help them compartmentalize and normalize back to center. A client can use the safe place and the container in-between session if the trauma becomes too strong and if they need a relief. Often symptoms of trauma increase instead of decrease as a result of the re-patterning and healing process. These two methods can help contain and compartmentalize some of the heightened symptoms.

- (2) Therapists need to be adept at tracking clients so they are aware of what is happening with a client within their ME-B system and how it relates to their thought process and memories.
- (3) Go slow enough so re-patterning at the brain and neurological level is possible. An EMDR electronic device is helpful for this process.
- (4) Never allow a client to over identify with the trauma or emotional feelings or sensations at the body or mind levels. Remind them that it is only a part of who they are – not all of them. Over identification of the trauma makes re-patterning and healing more difficult. However, in the beginning most clients tend to do this to some extent. Keep reminding them to re-center into all their parts, all their identity and not just the parts linked to the trauma.
- (5) Number 5 of the treatment plan speaks to the importance of energetic awareness and helping clients connect to the energetic reality of their true or divine self in all ME-B systems. To this end, Clients need to

learn to develop an internal “witness or observer” that **IS** identified with that deeper true self. If they witness their experience from their personality programming level, trauma does not seem to transform as effectively. Yet, if they learn to anchor into their true divine self in all three ME-B systems, then it seems optimum healing happens. This is why energetic awareness is key. The true or divine self actually resides on a different energetic dimension than our physical body and personality. It is very difficult to track this if the therapist is not trained to assess subtle energies. Subtle energies can be deeper than body sensation – although body sensations mirror back to us what is happening on the energetic level. So tingles and flows are body sensations telling us we are linked to our deeper true self. If the mind is connected to the dimension of our true self, with intention, it can bring that energy into the body. As this happens we feel pleasurable sensations as confirmation.

- (6) Never suggest a client to go deeper if they do not have deep connection to their true self or center either at the cognitive level, energetic or the body sensation level.
- (7) If a client disconnects from their center and over identifies with the trauma bring them back immediately. This often happens in the beginning before the client develops the skills necessary to re-pattern the trauma. It takes time, space and patience. This is especially true when the trauma has been with the client for many years and much of their personality and ego structure is linked to the trauma.
- (8) As mentioned earlier, always help clients identify with a safe place and their true divine self within them – from that point on – you can explore deeper.

- (9) Holding two-places at one time. This author teaches her students that if a client does not have at least a cognitive understanding of their true self, then accessing trauma should be postponed and therapy needs to focus on positive resourcing. A client that can connect to both the trauma as they also maintain a deep connection to their true self (holding two-places at one time) is ready for deeper transformational work. At the very least, they must be able to shuffle back and forth between their true self (at least in the mind if not all three ME-B systems) and the trauma.
- (10) For more treatment options, attend the Mind Energy Body Institute's trauma training or buy the curriculum for the training.

Although brain and neurological system functioning is still not completely understood, research clearly indicates the relationship between healthy brain maturation and the susceptibility to PTSD. Research also indicates that humans don't always respond instinctually to trauma in a way that encourages healthy recovery. Knowing how the ME-B system works can help inform which types of therapy are most effective in resolving past trauma and stress.

#### **HISTORY OF PTSD AND CURRENT DEFINITIONS**

In the history of psychology, PTSD is a relatively new diagnosis category (Rothschild, 2000). It first appeared in 1980 in the internationally accepted authority on psychology and psychodiagnosis, *Diagnostic and Statistical Manual of Mental Disorders*, 3<sup>rd</sup> Edition (DSM-III; APA, 1980) (Rothschild, 20002). The original definition was thought to be too narrow so they expanded the criteria in the subsequent revised DSM-IV. The essential feature of PTSD is the development of symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family

member or other close associate (Criterion A1) (DSM-IV, 2000). The person's response to the event must involve intense fear, helplessness, or horror (DSM-IV, 2000). PTSD can be acute, chronic or with delayed onset (DSM-IV, 2000).

Diagnostic Criteria in Adults:

The adult (children's criteria is slightly different) has been exposed to a traumatic event in which both of the following were present:

- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

The person's response involved intense fear, helplessness, or horror (DSM-IV, 2000).

B. The Traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions;
- (2) recurrent distressing dreams of the events;
- (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated);
- (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event;

physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event (DSM-IV, 2000).

C. Persistent avoidance of stimuli that is associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma;
- (2) efforts to avoid activities, places, or people that arouse recollections of the trauma;
- (3) inability to recall an important aspect of the trauma;
- (4) markedly diminished interest or participation in significant activities;
- (5) restricted range of affect (e.g., unable to have loving feelings); and
- (6) sense of a foreshortened future (DSM-IV, 2000).

D. Persistent symptoms of increased arousal that were not present before the trauma – as indicated by two or more of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance, and an
- (5) exaggerated startle response (DSM-IV, 2000).

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month (DSM-IV, 2000).

F. The event causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (DSM-IV, 2000).



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