

Trauma Therapy with Rosen Method Bodywork

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Abstract

This article answers questions such as: What is trauma? Who experiences it? Why do some people recover quickly and others have post-traumatic symptoms? Survivors who are ready for their healing journey need exactly what Rosen Method Bodywork (RMB) offers: restoration of embodied self-awareness and the experience of connection to a larger self and to an empathetic other who is trained in self-awareness. The way Rosen Method practitioners integrate the use of touch, words and attention to the diaphragm initiates the creation of physiological changes needed to heal from trauma: “rewiring” implicit traumatic memories into explicit (autobiographical) memories, integrating neural networks, and calming an over-activated nervous system.

Practitioners can benefit from being aware of how RMB differs from other approaches in allowing a process to unfold rather than “fixing” the client. Recovery is less a process of revisiting traumatic memories and more that of gaining the choice to give up old survival patterns, many of which are internalizations of abuse or neglect. This will feel life-threatening to survivors, and practitioners need to be able to contain the strong feelings that may come up, such as terror, rage, despair, shame and self-loathing. Recovery usually takes place in increments over time and will contribute to Post Traumatic Growth. Throughout the article, concepts are illustrated with personal stories in case reports.

Introduction

I have been a Rosen Method Bodywork (RMB) practitioner since 1996. When I began the training, I had no idea that I had been living my whole life with the symptoms of trauma. I did not understand why it was so difficult for me to learn RMB until the day I finally landed in my body. It seemed as if the world changed overnight. I did not launch my Rosen Method practice thinking I would “specialize” in working with trauma survivors, but only a handful of my clients have not been affected by trauma. However, I have come to understand that when clients are at the right stage of their healing process, RMB is particularly suited for treating trauma.

I'd like to share the experience of my journey from survivor to thriver, both as a student learner and as a practitioner walking with clients through their healing process. My intention is to “give flesh” to the clinical descriptions of symptoms so that practitioners can be aware of what they encounter. In Part 1, I discuss what trauma is and which survivors are appropriate RMB clients. Part 2 describes how the components of RMB support the physiological changes necessary to healing. Part 3 offers specific guidelines for RMB practitioners to help them understand and engage effectively with what they may encounter with trauma survivors. Part 4 is about seeing results, describing the spiral stages of healing. Finally, Part 5 describes what life may be like after recovery, including the experience of post-traumatic growth.

Part 1: Defining Trauma and Identifying Appropriate Clients

What is trauma?

Marion MacCurdy's definition of trauma describes its overarching impact. **Trauma**

is any assault to the body or psyche that is so overwhelming that it cannot be integrated into consciousness...an event that shatters belief systems about life...the assumption that the self is sufficiently competent to act, that people are generally good, that the world has meaning and is predictable. Trauma breaches the unspoken contract we think we have with life, that if we do what we are supposed to do we will survive (MacCurdy, 2007, p. 16).

I have always wondered, *why* do we think we have this unspoken contract with life? I got my answer from Peter Levine:

Human beings have been designed over millennia, through natural selection and social evolution, to live with and to move through extreme events and loss, and to process feelings of helplessness and terror *without* becoming stuck or traumatized (Levine, 2010, p. 180).

Extreme events and losses are a regular part of life, and our bodies have the capacity to heal. If that is so, why do some people end up in the state described by MacCurdy?

Who is a trauma survivor, and who develops symptoms?

If trauma is defined as an experience of becoming overwhelmed by a terrifying event that one could not immediately integrate, then I believe everyone is a trauma survivor. However, not everyone develops the symptoms associated with trauma or post-traumatic stress. "Studies suggest that for one-time events, the vast majority (more than 80%) of individuals will be able to cope with a stressful experience and in the long run not develop a post-traumatic disorder" (Siegel, 2012, p. 39-2).

The development of symptoms depends on a variety of factors and cannot be predicted by the nature of the event itself. Sometimes a seemingly benign circumstance can be traumatic, especially to a child who is sensitive to factors that others may not consider serious. An experience that would overwhelm one person might not affect another the same way. Much depends on predisposition, previous history, timing and context. For example, rape survivors who get immediate support do not necessarily end up with long-term trauma symptoms. Also, trauma can develop not from one single event but from a prolonged atmosphere of neglect or inconsistent care (For more information, see Green, 2014).

Judith Herman distinguished the consequences of simple trauma (a one-time event) from "prolonged, repeated trauma" (Herman, 1992, p. 119). After a single trauma, survivors may say "I'm not the same person I was before;" after long-term trauma, they say things like, "I'm not a person. I don't exist. I'm nobody." After simple trauma, it's "I feel like I'm losing my mind." With complex trauma, it's "I've lost my self"

In RMB, we have to be able to sense and contact that lost Self and engage it in the healing process.

I as the practitioner must continue to be aware of the whole person, even when clients are aware only of their pain or numbness. I remind them that we are here to get in touch with that Self who can help in the present moment. My trust that this Self exists and can make a difference keeps me confident that healing can happen. If I can't find this part because the person's life or psyche is in too much chaos, I don't work with them (see below for guidelines about people for whom RMB is more likely to be effective).

Trauma is not readily recognized or acknowledged in our culture, and even when it is, we are too often expected to get over it just because it is behind us. We are expected to stop grieving the loss of a loved one in a few weeks, to have no repercussions after a successful surgery, to proceed as if nothing happened after coming home from war. What is worse, we often do not acknowledge circumstances as having a traumatic effect, even "obvious" ones such as having a disability or being exposed to violence. This denial from the outside undermines a person's sense of self and reality, making it very difficult to go on living as if the world makes sense or life has meaning. Trauma has to be acknowledged, recognized and brought out of secrecy and denial.

Child abuse and neglect are examples of such an easily overlooked source of trauma. Over the years, I have worked with so many clients who report childhood abuse that I began to wonder how common it is. I recently learned about a study of **Adverse Childhood Experiences** (ACE's) that gives us a picture. Jane Ellen Stevens, the editor of an online newsletter called, *ACEs Too High* (2012), reports:

The ACE Study, which began as a joint research project of Kaiser Permanente in San Diego and the U.S. Center for Disease Control and Prevention, looked at ten different types of childhood trauma...physical, sexual, and emotional abuse; physical and emotional neglect...and five types of family dysfunction: a parent who's an alcoholic or diagnosed mentally ill, a battered mother, a family member in prison, and a parent who disappears through abandonment or divorce.

The picture is a bit grim:

- Only 33% of us have no ACE's.
- They rarely appear alone—if there's one type of childhood trauma, there is 87% likelihood that there are others.
- They are very common even in predominantly white, middle-to-upper-class, college-educated Americans.

In other words, approximately 2/3 of the people you meet have experienced an ACE of the sort listed above. One in six in the study had an ACE score of four or more out of ten; one in nine had five or more types of trauma.

The doctors and epidemiologists who conducted the ACE's study were shocked when they found a direct link between the number of ACEs and chronic disease, mental illness, imprisonment, work-related issues, and cancer. "Compared with people with zero ACE's, those with four...had a 240% greater risk of hepatitis, were 390% more likely to have chronic obstructive pulmonary disease..." and the list goes on to include alcoholism, drug addiction, suicide attempts, auto-immune disease, broken bones, and the use of medications.

Although doctors may be surprised by the link between physical ailments and emotional issues, Marion Rosen would not. That is exactly what we are addressing in our Rosen Method practices, but this brings us to our next question.

Which trauma survivors are appropriate clients for RMB?

Judith Herman has outlined three stages necessary for recovering from trauma: getting safe, remembering and mourning, and building a new life. “A form of therapy that may be useful for a patient at one stage may be of little use or even harmful to the same patient at another stage” (Herman, 1992, p. 156). Each stage also requires a certain set of conditions to be in place.

The deep uncovering work Rosen Method offers is best started when a person's life is safe, stable, and supported. If someone lives with an abusive spouse, for instance, RMB may start to dissolve coping mechanisms that are still necessary. The first step in recovery from trauma is to get safe: actually safe, not just pretend safe or thinking one is safe when not. By the way, this is one of the symptoms of trauma: people are not able to discern what is really dangerous and what is not. This shows up in dramatic ways (walking alone at night in bad neighborhoods) or subtle ways (taking their clothes off before the practitioner has had a chance to leave the room and shut the door).

Clients need to have stable lives. If they don't have a job or a home, if they are in some kind of current crisis, if they are in active addiction, if they go from one bad relationship to another—these are signs that the circumstances of their lives cannot sustain RMB. They may need the help of therapists or social workers first to create a life that works for them, and they should also have support systems in their lives—family members, friends, professionals, or groups.

The Rosen Institute's Scope of Practice states explicitly that RMB is contraindicated for:

- Individuals who have a serious psychiatric condition that is not effectively managed by medication and who have not received medical consent for Rosen Method Bodywork from their psychiatric provider
- Individuals who are currently experiencing mental health or psychiatric disorders such as psychosis, schizophrenia, severe anxiety or depression, mania, or are suicidal with intention and concrete plans
- Individuals with active drug or alcohol addiction.

As people come out of these states with the help of therapy, they may at some point want to add RMB to their support system. Many psychotherapists refer clients to me so we can work in collaboration. If a client already in therapy comes to me, I make sure that their therapist knows and approves of doing bodywork at this juncture. And sometimes I can see how RMB would benefit someone, but I tell them I will work with them only if they are also seeing a psychotherapist as a prerequisite or necessary support for RMB. For some of my trauma survivors, I am the only treatment provider.

One of my clients came up with a perfect way to think of the role of RMB. He said, “Some people need solvent, and some need glue.” At different times in one's life, one or the other is needed. Among the agreements I ask the client to sign on my intake form, one is that if a certain level of trauma emerges during the work, I may refer them to a psychotherapist. Perhaps we discover that they need more “glue” instead of “solvent,” or at least a combination of the two. I can remind them of the distinction between my services and that of a therapist. If they have already made the agreement, at least they won't be surprised.

Part 2: General Principles for Working with Survivors

Recognizing trauma

Even though my intake form asks clients to circle a list of problems including trauma, that word is rarely circled. I believe trauma is so common, we don't even recognize it as such. Years ago, during a session with a new client, I began to wonder why she seemed so "unreal" to me, so I asked if she had ever experienced trauma. She said no, she could not think of anything. After a while, she remembered well, that there was the time when her uncle chased her and her mother around the house shooting at them...was that trauma?

As shocked as I was at the time, I have come to realize that denial and minimizing are some of the chief ways people manage to live through trauma and go on. They may even forget particular events or even whole chunks of life completely. These are built-in survival tools of the nervous system; people do not consciously choose them and often do not even know they are operating. RMB helps them become aware of these survival patterns and helps them see the connection between past events and current issues.

Trauma symptoms develop when a person's nervous system is overwhelmed without sufficient resources to bring it back to a regulated state. Without needed resources, survival patterns develop that the client is not even aware of. My clients are generally well-functioning and may not come in identifying themselves as trauma survivors; nevertheless, they complain of anxiety and self-doubt, fibromyalgia, back pain, or other physical ailments, or say they are stuck in some aspect of their lives and cannot move forward. Over the course of treatment, we often come to some overpowering memory as MacCurdy defines trauma. It could be a single incident that no one recognized as traumatic for the individual, or it could be a pervasive atmosphere of unsafety at home, or school, or in the workplace.

Trauma reactions can develop even from "normal" experiences, many of which could have been easily dealt with if the person had social support. But many of my clients have experienced terrible events that pass as normal life, going unnoticed and unmentioned to anyone. They have endured the schoolyard bully who damaged their body, the drunken father they had to scrape off the driveway, the dentists with wandering hands. These clients spent years not knowing that their experience could have developed into trauma symptoms because it was so unremarkable in the context of their lives, or because it was so long ago.

Then there are the others who did not suffer a one-time trauma, but lived with neglect, verbal abuse, or criticism. They blame themselves even more than the others for their difficulties, because "nothing ever happened" to them, so they do not qualify. They are very aware that others have experienced violence, poverty, and catastrophe; having parents who belittled them seems tame in comparison. Even if their minds are telling them they cannot have post-traumatic stress, their bodies will affirm it when you name it. One client who could not feel her emotions asked in despair, "What's *wrong* with me?" I suggested that she was trying to recover from trauma. She instantly had tears and her diaphragm relaxed.

Others, like me in the past, do not know that they are trauma survivors because they do not know about **secondary trauma**—having witnessed or been repeatedly exposed to the traumas of other people, particularly their loved ones.

Knowing the symptoms of Post-Traumatic Stress Disorder

Many survivors do not know that the way they live is not everyone's universal experience. Or, it could go the other way: some of their symptoms are so overwhelming that they think they are alone in their "craziness." After getting certified, I attended a weekend Rosen Method workshop on trauma. We were given the then (1996) official DSM (*Diagnostic and Statistical Manual*) list of **PTSD (Post Traumatic Stress Disorder)** symptoms (see Table 1). I had almost every single one of them and was surprised because I had never experienced even so much as a light spanking by my parents. On the DSM's list of people who qualify for PTSD are those who have secondary trauma.

Light bulb moment: my parents and grandparents were genocide survivors, as were my aunts, uncles, and cousins—as a matter of fact, every Armenian we knew. Genocide. Civil war. Revolution. Atrocity stories were common dinnertime conversations whenever we got together with other Armenians. Trauma was my heritage. Before I learned about how the nervous system develops (see Fogel, 2009), I called it "drinking in fear with mother's milk." If that were not enough,

... recent discoveries in the field of epigenetics have ... revealed that alterations in the control molecules regulating gene expression may also be important in this intergenerational passage of patterns of communication. For example, the experience of extreme stress in one generation may be passed on through gametes, the egg and sperm, such that the ability to regulate stress may be compromised in future generations (Siegel, 2012, p. 2-3).

Imagine my thoughts and feelings when my "normal life" turned out to be a list of PTSD symptoms from the DSM, described in Table 1 below. Ever since I was a child, this was what my life was like. I didn't realize until sometime during my Rosen Method training that it was different, so I started asking friends if they reacted to things (news, sounds, financial setbacks, etc.) the way I did. No. Once when I lived in an apartment in Rochester, New York, I heard a tremendous explosion and saw large pieces of ash raining down on my street. I called a friend in panic and heard myself ask, "If I run out, will they shoot?" *What?* Am I crazy? Where did that come from?

Family stories, that is where, and epigenetics. The way I felt inside myself then, now helps me understand my survivor clients. If they do not remember or have minimized their traumatic events, or do not know about secondary trauma, they will be triggered by the most innocent of clues and not know why they are "losing their minds." The practitioner needs to know and be there to recognize the symptoms.

TABLE 1: DIAGNOSTIC CRITERIA FOR POSTTRAUMATIC STRESS DISORDER (PTSD)

Symptom	Description	How I experienced it	My observations of clients
intrusions	recurrent, involuntary and intrusive memories; nightmares; flashbacks; physiological reactivity to trauma-related stimuli	I began to realize I had PTSD when I counted how many times per day I'd see unbidden scenes of torture or atrocities in my mind's eye. (I stopped counting at 40.)	re-experiencing the sensations and emotions of the event (like dizziness, throat closing off), often when triggered by particular locations, sights or sounds
avoidance	efforts to avoid thoughts, feelings, or conversations; activities associated with the trauma	I still can't look at injuries, TV surgeries, pictures of cadavers in anatomy books, etc. or read about violent injuries. Forget gory movies!	reluctant to come to Rosen Method sessions; reluctant to speak what they feel or remember; avoid certain activities with their families
detachment or estrangement	feeling alienated or estranged from others	I felt so isolated that I did not know that even those "close" to me could know my deepest self. At times, I felt so alone that I was the only thing in existence	feeling others are normal and I am not; I don't belong; no one knows, should know or can know what I experience
restricted range of affect	feeling disconnected from own feelings and emotions, numb	For years I did not know what I was feeling emotionally. I was even physically unresponsive to what should have felt like a lot of pain.	flat affect; able to tolerate a lot of painful emotion and physical pain without complaint; difficult to access certain feelings (grief, rage, etc.)
sense of a foreshortened future	does not expect to have a career, marriage, children, a normal life span	if there was a future, it was bound to be bad: I was terrified of being a bag lady.	convinced that everything good in life is about to disappear (including practitioner)
insomnia	unable to fall or stay asleep; chronic insomnia lasts more than a month	since childhood, it took a long time to fall asleep, woke up in middle of the night, in adulthood sometimes didn't get more than 2 hrs sleep a night for weeks	never feeling rested and restored

Symptom	Description	How I experienced it	My observations of clients
hypervigilance and exaggerated startle response	always being on guard or alert, quick to startle	I couldn't sit with my back to a door in restaurants. My spine jumps when someone approaches me from behind. I am acutely aware of what is occurring on the street—all 360 degrees.	can't really lie down on the table; sometimes can't let themselves close their eyes; can't receive touch; have to be in control

An Example of PTSD Symptoms: Flashbacks

We are not always aware that our experiences could reflect symptoms of PTSD. I have seen this occur in relation to **flashbacks**, a form of intrusive memories. It helps to know how flashbacks are experienced, because clients can experience them even when they do not remember the trauma. Often, flashbacks do not come with images or memories, but instead with pure bodily sensations, emotions, and irrational thoughts. We all understand that war veterans, for instance, can be triggered by a loud sound, but at least they know they have been at war. Imagine how terrifying this would be if you do not remember the childhood abuse or other trauma, but suddenly in the middle of a perfectly ordinary event, you are overwhelmed with thoughts and feelings that make no sense.

The first time I met with a client I'll call Mary, she told me about an event that happened 25 years before and still haunts her. She saw a dilapidated cabin in the woods and became overwhelmed with darkness and despair. Her thoughts were inexplicable to her: Why would a cabin make you want to double over and throw up? What was the meaning of anything if you just die? She asked herself, who thinks thoughts like this? Only a crazy person would, right? And, why had she spent the next 25 years hanging on by her fingernails as if she was about to fall into an abyss?

Mary was ten years old when she was violently attacked by her adult brother. Unable to fight or flee, she went into freeze mode—scared stiff. The attack continued, and she had “to fold”—collapse into helplessness. Eventually, when the rapist finally left but no help arrived, a part of her that was determined to survive got up like a ghost rising out of the body. This part (later named “Survivor”) continued living the person's life like a zombie going through the motions, often very convincingly. Meanwhile, the hurt child is still deep in the adult's body, lost in terror and screaming without voice. She's right under the diaphragm that remains habitually held like a vise.

Mary described herself as “living inside plexiglass.” Peter Levine could be describing her life:

While traumatized humans don't actually remain physically paralyzed, they do get lost in a kind of anxious fog, a chronic partial shutdown, dissociation, lingering depression, and numbness. Many are able to earn a living and/or raise a family in a kind of 'functional freeze' that severely limits their enjoyment of life” (Levine, 2010, p. 52).

Early in her Rosen Method process, Mary despaired about whether anything could free her of the plexiglass. To continue using the metaphor, I felt that my job was to melt the plexiglass with love. “**Love** is a meeting in the subjective emotional present of embodied beings who lay bare their vulnerabilities” (Fogel, 2009, p. 278). Love, contact and presence were the solvent, and I was able to have direct conversations with the hurt child, who finally, *finally* had someone show up to help her. She tells me things the adult cannot.

During that first visit, Mary had mentioned sexual abuse, but had not said much about it. The sheer physical and emotional overwhelm of this “cabin” event, however, sounded exactly like other descriptions I had heard from people who were aware they were having a flashback. So, I suggested that’s what I thought it could be - a flashback about events she did not remember at the time of the flashback. This was a door opening to a long journey of healing from a violent and scary childhood.

The Physiology of Self-Regulation as a Result of RMB Sessions

The three cornerstones of RMB—touch, words, and attention to breath— are essential for healing trauma in ways I will explain in this section. RMB practitioners coordinate the use of these elements in a unique way that enhances awareness and integration.

Trauma symptoms aren’t just “in the head.” Trauma causes physiological damage and can change one’s brain, neurohormones, organs, and cells. “Trauma memory is as much in the sensory receptors, in the skin and in the muscles as it is in the brain” (Fogel, 2009, p. 259). Therefore, a treatment approach that does not include the body is incomplete. Likewise, bodywork that does not bring the client to conscious self-awareness is incomplete for healing trauma. **Embodied self-awareness** “is the ability to pay attention to ourselves, to feel our sensations, emotions, and movements online, in the present moment, without the mediating influence of judgmental thoughts...” (Fogel, 2009, p. 1-2)

Fogel delineates the restorative nature of embodied self-awareness:

It allows us to feel ourselves without suppression and yet stay in an emotionally safe zone; it engenders self-trust and the ability to respond appropriately and effectively in current situations; it helps us make choices true to our own needs and values and also use others as resources; it’s a requirement for creativity and engagement. Furthermore, this ability to be our true selves opens interpersonal and spiritual dimensions of compassion, forgiveness and gratitude (Fogel, 2009, p. 294).

All this is exactly the opposite of living with the symptoms of trauma.

According to Bessel van der Kolk, one of the foremost researchers in Post-Traumatic Stress Disorder (PTSD), “the only part of the conscious brain that is capable of influencing emotional states...is the part that is involved in introspection (i.e., attending to the internal states of the organism)” (Ogden, 2006, p. xxv). Notice how his description of what is needed aligns with what RMB is all about:

In order to deal with the past, traumatized people need to activate...their capacity for introspection. Therapy needs to help them develop a deep curiosity about their internal experience. This curiosity is essential in learning to identify their physical sensations and to translate their emotions and sensations into communicable

language—communicable, most of all, to themselves (Ogden, 2006, p. xxvi).

RMB touch and connection as necessary components of healing

The Rosen Method practitioner's effectiveness is completely dependent on a deep connection with the client. "Recovery can take place only within the context of relationships; it cannot occur in isolation" (Herman, 1992, p. 143). Since loss of connection from others or within the body characterizes a trauma reaction, it is essential to restore empathetic resonance. Human beings have evolved to need safe, nurturing connections with others so that we can do everything from developing our nervous systems as babies to restoring our bodies and minds to balance as adults (Green, 2014). RMB touch embodies meeting, listening, and taking in, rather than manipulating or doing something to, the client. In *Touching the Body, Reaching the Soul: How Touch Influences the Nature of Human Beings*, Sandra Wooten "coined the term **somatic resonance** to define the matching that takes place with gentle, therapeutic (Rosen Method) touch, between the client and practitioner, allowing enhanced inward attention and perception for both" (Wooten, 1995, p.24).

"The power of human contact to help change another's internal physiological state (through face-to-face engagement and appropriate touch) should not be underestimated" (Levine, 2010, p. 107). Love, touch and belonging are physiological needs so strong that their absence can cause trauma and even death, as Ashley Montague made clear in his reports on babies in orphanages (Montagu, 1978, pp.76-79).

When RMB practitioners touch their clients, they are establishing the conditions that allow clients to relax into a sense of being truly met and understood by another. A body-to-body, mind-to-mind develops that contradicts the trauma experience. In her article, "Resonance, Regulation and Revision: Rosen Method Meets the Growing Edge of Neurological Research," Dorothea Hrossowyc describes the research about how this works and concludes, "Relationship, through the healing cascade of the human connection system, regulates and revises our neurological health and our physiological functioning" (Hrossowyc, 2009, p.9). With RMB, the inherent need for love and safety is met, and the client's bodymind can heal.

I use the word **bodymind** throughout this article because this is a better description of who we are and how we function. According to Candace Pert, "Your brain is extremely well integrated with the rest of your body at a molecular level, so much so that the term *mobile brain* is an apt description of the psychosomatic network through which intelligent information travels from one system to another" (Pert, 1997, p. 189). Thus, "intelligence is located not only in the brain but in cells that are distributed throughout the body, and...the traditional separation of mental processes, including emotions, from the body is no longer valid" (Pert, p. 187).

Because unwanted touch is often a component of abuse, clients can react either by not wanting any at all, or by accepting it, but dissociating without realizing it. For example, one client had received years of massage without really being present in her body; when it came time for Rosen Method work, I had to stay aware of when she was staying and really connecting, and when she would "leave." The client is in charge of when, where, and how long I touch, but I am in charge of not letting her either shut down to being touched without being aware of it, or ignoring the fear that comes up. As a matter of fact, engaging with the fear is exactly what needs to happen. I back off only as much as I need in order to help them stay present and sense what they feel and need.

Having survived in silence and isolation, trauma clients may not know they need you, or anyone. Sometimes, as the practitioner, I get the feeling that the client is trying to “do” the session alone. They are “being a good client” and telling the stories, and maybe even feeling their feelings, but all this effort is occurring without engagement with the practitioner. This is what survivors are used to: being on their own. They do not even know they're doing it, so the practitioner has to make them aware of it and teach them a different way: *See if you can feel my hand. What does that feel like to you?* They might think you are changing the subject or asking irrelevant questions. When you insist that establishing a present-time connection between you is crucial, they will have a hard time believing you. This may be a good time to educate them about how touch and connection can transform memory, described in the following section. Otherwise, they can go on with their stories and their emoting without any actual change in their body or psyche.

Transformation and regulation of memory networks

Let us take a look at how memories are formed. Why are traumatic memories different from others, and how can they become integrated? We are familiar with the story-telling memory, by which we communicate life events. This is called autobiographical, declarative or **explicit** memory. It is organized by a part of our brain called the hippocampus and is part of our conceptual self-awareness, the conscious idea of ourselves. Then, there is the kind of memory that may not be conscious, but is implicit or held in the body, for instance, how we ride a bicycle or play an instrument. When called upon, **implicit** memory is felt in relevant body parts but has no words attached to it. Emotional memories are like implicit memories. They are packaged in parts of the brain like the insula and others. Often, we experience the two kinds of memories simultaneously, gesturing or emoting when we tell a story.

To simplify, let us say the hippocampus helps you locate your memories in space and time, and the insula connects memories to your cortex (thinking). Alas, during a traumatic event the normal functioning of these brain parts is interrupted. Alan Fogel describes what happens:

Dissociation during trauma inhibits the insula and the hippocampus from binding the memories into cohesive packages, whereas attention to the trauma assists the consolidation of memories ... Memory may ... appear in extremely vivid bursts with disturbing sensory details, flashbacks, feelings of panic, anger and terror all of which are sudden, intrusive and frightening because they seem to come from nowhere and can't seem to be regulated in conceptual-autobiographical self-awareness. ...It is as if the traumatic event is “locked inside” because the unrealized urges—the failure to be able to act as one would have expected—which have not been integrated...are in a sense holding the neural network hostage (Fogel, 2009, pp. 258-259).

This explains flashbacks and survivors’ feelings that they are reliving, in the present, the event that traumatized them. In addition, the somatization of symptoms makes sense. Survivors had to hold back from fight or flight, so there's a lot of tension in arms or legs; they couldn't scream, cry, or speak, so the neck, jaw, and throat are in trouble; they could not breathe and the chest or belly are tight. Survivors may have all kinds of aches and pains, problems with digestion or elimination, dizziness, and other physical symptoms that are not explained by current pathology and conventional medicine.

Fogel calls the kind of memory that feels like a ‘reliving’ **participatory memory** because it is an experience, not a story. The goal is to “rewire” this memory into autobiographical memory. The good news is that new neural pathways to the insula can be formed, and the hippocampus is one of the places in the

brain that can grow new nerve cells even into adulthood. Remember, this is the brain part that can organize sensory impressions into coherent events that occurred in a particular time and place, and had a beginning, middle, and end. The result is that traumatic events can be integrated into the whole person and become a comprehensible part of that person's life history. Survivors become either less and less affected by their traumatic memory reactions or no longer triggered or baffled by them.

Researchers working with animals and humans have discovered that "every time a memory is retrieved, the brain breaks some of the chemical bonds that make up its physical foundation. As a result, memories become unstable for a brief time after their retrieval" (Dingfelder, 2010, p.1 quoting Joseph LeDoux). In the ten-minute to six-hour time period of instability, the brain can experience new learning.

This process turns off a learned emotional response at its roots, not by merely suppressing it...but by actually unlocking the neural connections holding it in place and then erasing it within the nervous system...What the brain requires...is the same three step process [in the ten species studied, including humans]: reactivating the emotional response, unlocking the synapses maintaining it, and then creating new learning that unlearns, rewrites and replaces the unlocked target learning (Ecker, 2013, p. 21).

Our bodies have a neurotransmitter called gamma-aminobutyric acid, or **GABA** for short, whose function is to soothe, to bring sensations of pleasure and comfort. "Research suggests that GABA-bearing fibers—literally fibers of comfort—[grow] from the orbitofrontal cortex into the terror-filled amygdala [the part of the limbic system that detects threats and processes fear]. This kind of vertical integration...bring[s] the neural network containing the representations of the trauma into the embrace of interpersonal care" (Badenoch, 2008, p. 317). Even when people remember an original experience, this memory is stored separately from the "emotional learning" they derived from it—that they are worthless, helpless, invisible, that the world is never safe. These emotional effects of the memory change without changing the actual memory (Ecker, 2013, p. 21).

In other words, for RMB practitioners, when a client on the table is being touched in a safe and attentive way, she or he senses the presence of the practitioner who is not hurting her, but containing, protecting, and regulating her. It's not enough to have a verbal assurance of safety; touch makes it a concrete experience. So, enough of the "plexiglass" thaws out that her body begins to reveal what it has suppressed: shaking, intolerable fear, tears, wanting to run but being trapped, etc. Her old expectation is that when these sensations and feelings arise, she is in actual danger and she will be ignored or further abused - yelled at, punished, banished - by her "caretakers." Instead, what she experiences is being touched and cared for, which releases oxytocin, the neurohormone that calms an aroused nervous system. "If that new experience of our self in relationship is awash with oxytocin, if we 'feel' safe and loved and cherished strongly enough in that split second of re-wiring, the more positive oxytocin-based sense of self in relationship will contradict and trump the old negative message or script" (Graham, 2010, p. 5).

On several occasions, clients have been aware of this process without being conscious of what happened on a neurological level. One client repeated over and over during a session, "Something deep is changing." Once, Mary (introduced earlier) experienced a very vivid "reliving" which made her sit up on the table. However, she had the love and containment of her practitioner (plus this happened within the container of an intensive)—the exact conditions described by Ecker. She describes the results:

In that session, I had a body memory of my abuser sitting on my chest; I couldn't breathe. I had to sit up. I believe it was being met there with love—the trauma came up and love touched it—that's why I didn't get stuck in it. Afterwards, I had so much energy I *had* to take a walk. Outside, it was like the light changed, heaven opened up to me. I felt expansion, openness in my torso area, grounded, landed in my body.

Much later, I asked her if there were any long-term effects from that session. She said, "Over the long run – very long for me because the trauma was so immense - I needed that to keep moving towards healing. I continue to get new moments of connection and landing. They don't last long, but each time they happen, they inform the present and the future. They happen more often and last longer, and that's way better than never."

I am amazed at another phenomenon that at least two clients have reported after experiences that we call "rewiring" happened. One had a dream, and another experienced a waking image of something they didn't understand: a kind of web or network, strings trying to connect, lights shooting off chaotically. Both of their descriptions brought to mind images I have seen of neural networks and synapses. One asked, "Why, if it looked so scary and chaotic, did I feel good when I saw it?" Just after that, she had a session in which she was able to risk landing in her deepest pain, only to find out that it had a beginning, a middle, and an end - in five minutes. My conclusions are that people can be self-aware enough to feel and "see" their brains at work, and that when new neural connections are made, "hours, days, weeks later," (as the above client reported) they "have access to new thoughts, can make connections I never made before."

Why the diaphragm matters so much

Imagine that something suddenly scares you. What are your skeletal muscles and the diaphragm doing? They contract – they contract to control emotion, but also to mobilize. Let's say you are under attack: stress hormones are increasing your heart rate and your breathing; they inform your muscles to move. You need more oxygen, which is why there is a strong connection between your diaphragm and your limbic system—the part of the brain that regulates emotion and memory. Now let us say that you frightened off the attacker, escaped, or were rescued. Whew! Maybe now you can have your feelings about the event, shaking, crying, or getting angry. Your breathing can slow down and you can start to relax. Soon, your well-being will be restored. The event becomes a memory you can tell a story about, thus it has no long-lasting effects.

What if things don't go that well? And, what if you are in danger for long periods of time? If you don't have the conditions under which you can recover, like getting immediate help, then the bodymind goes down a different path. The amygdala, responsible for detecting danger, changes to become more sensitive to threat. In addition, it stays "turned on" because nerves from your contracted diaphragm report back to the amygdala that a threat is still present, even when it is not. This in turn, makes your brain seek and find danger in the present, long after the traumatic event is over. In this recurring feedback loop, as long as the amygdala detects danger, the diaphragm will be unable to fully move.

Getting enough air is not the only reason why a freely moving diaphragm is important. During a traumatic event, our bodymind does not slow down to let us consider what our emotions are. Sometimes we even respond to threat before we are aware of it. Feeling what we feel is not our priority; getting safe or shutting down are pivotal then.

Put simply, our bodies are involved in the experience and activity of defense, rather than the experience and activity of the emotional content that is motivating that defense. The emotional content with its associated memories, images and thoughts is not readily available for us to feel or know (Green, 2013, p.17).

As long as the diaphragm is contracted, we have less way of knowing and responding to our own internal states, our emotions, or needs. We are cut off from our Authentic Selves.

In order to break this feedback loop, the diaphragm needs input from outside the system to reset itself to a more relaxed state. This means the bodymind needs to experience safety and empathetic connection, which is what the Rosen Method touch provides. It's not enough to "know" in our heads that the danger is over and we are now safe. The body has not truly experienced this, and it will not believe the mind because what happened to it during the trauma has not physiologically changed or transformed.

Thank goodness for all the recent research that has revealed the brain and nervous system are not static, but can change with new experiences. The conditions established in a Rosen Method session allow the body to take advantage of this **neuroplasticity**. Aware touch induces a cascade of effects: it activates the parasympathetic nervous system, which brings the bodymind to a more rest-relax-and-restore condition. Thereby, it reduces the sympathetic cortisol level and elevates the parasympathetic oxytocin level. Oxytocin is a hormone and neurotransmitter stimulating feelings of connection, nourishment, and well-being. At the same time, it lowers blood pressure and heart rate, and ushers in the body's ability to restore itself. And there are other physiological changes (summarized here but delineated further in Fogel, Hrossowyc and Graham):

- Oxytocin receptors in the brain increase in number.
- Overused connections between the amygdala and the anterior cingulate cortex - brain parts to sense fear and threat - are calmed down so the world does not always seem scary.
- Mirror neurons in the parietal lobe of the brain, which fire when we watch others do movements we can do, are activated. This helps the client sense their body size, shape, location, boundaries and relationships between body parts.
- Genes that regulate stress hormones are "expressed" or turned on.

The components of RMB support this process. Gentle touch helps the body to relax, making it safe for the client to return to the body and feel him or herself. "Touch...can create the growth of linked cellular pathways along the neuraxis to encode and enhance embodied self-awareness" (Fogel, 2009, p. 217). The use of words in RMB adds verbal expression to non-verbal experiences that were not recognized or integrated. This opens doors to even deeper awareness and integration.

How words elicit integration and healing

Without integration, body, mind and soul are in bits—a jigsaw puzzle that does not quite fit together. Survivors may know one thing but feel another; act cheerful on the outside, but feel desperate and hopeless on the inside. Accomplished professionals may feel like terrified children. These disparate feelings and behaviors go on, each in their own tracks, mindless of each other. **Integration**, therefore, is experienced as oneness with oneself. One is aware of what one thinks, feels, and senses. Even when contradictory internal experiences are going on, there is an observing self that can make sense of the current situation and act on behalf of one's well-being. Integration includes the capacity to tolerate uncertainty, "emptiness" and mystery,

which is where creativity comes from. Integration allows for self-trust.

Years ago when I was a student at an intensive, we were being led through a guided meditation that included the image of meeting a guide or helper of some sort. My guide appeared on the movie screen before my mind's eye: a tall, glowing figure radiating wisdom and love. I was beginning to feel good. Suddenly, I realized that the screen had two halves. My beautiful guide was on the right side; on the left there was another scene going on, *and it had been going on the whole time without my notice*. On this side, people were running out of burning houses and being shot dead. I was shocked to find out this was in my mind all the time. How could I not have known? What happened that I suddenly woke up to it?

Neuroscience research helps to understand such experiences: how neural networks that are not connected (for example, the right and left sides of my screen) can make a connection. "When someone is traumatized, we...know that the neural circuits containing that experience are often prevented from integrating with the rest of the brain, so they lie in wait like a time bomb, only to be triggered by reminders in the external world at a later date" (Badenoch, 2008, p. 316). This is similar to how flashback memories become disconnected from autobiographical memory, how the sensory and motor parts of the memory become disconnected from a coherent verbal story about oneself.

The damage of trauma is not some abstract psychological state. It is a frontal cortex that is not able to regulate the fear from the amygdala; a corpus callosum that is underdeveloped, so the left and right hemisphere can not communicate. In children who have suffered neglect, "stress may cause excessive pruning of neural connections between the hemispheres and disrupt genetically prompted myelination of these pathways, making it difficult...to generate words for feelings or create a meaningful and containing story of inner experience..." (Badenoch, 2008, p. 139). One network does not connect with the other. It is like walking in the woods, and when you nearly step on something that scares you, the part of the brain that knows it is a stick cannot communicate with the part of the brain that is freaking out because it "feels" like a snake.

Integration, it turns out, is physiological. We've seen how touch and attention to the diaphragm can help the process. Finding our words is just as crucial.

In PET scan studies of people with PTSD who were purposefully triggered, "there is an increase in perfusion of the areas in the right hemisphere associated with emotional states and autonomic arousal. Moreover, there is a simultaneous decrease in oxygen utilization in Broca's area — the region in the...cortex responsible for generating words to attach to internal experience. These feelings may account for the observation that trauma may lead to 'speechless terror,' which in some individuals interferes with the ability to put feelings into words, leaving emotions to be mutely expressed by dysfunction of the body" (van der Kolk, quoted in MacCurdy, 2007, p. 32).

That is one reason why Rosen Method clients may come to see us because of physical problems, and why they cannot connect these symptoms in a meaningful way to their emotional experiences, or cannot discern the relevance of one event to subsequent events or behavior. They are unable to find words for their internal experience, and that is one of the things we, as Rosen Method practitioners, are helping them do.

The goal in effecting healing is to combine the images, and the emotions they generate, with thought processes, and this can be done only through activation of the verbal system. As van der Kolk said, "A sudden and passively endured trauma is relived repeatedly, until a person learns to remember simultaneously the affect and cognition associated with the trauma through access to language" (MacCurdy, 2007, p. 33).

Rosen Method practitioners use words the same way they use their hands: they make contact, contain, inquire, meet, reflect, and deepen. The way we talk is akin to the touch. "Words... become the manifestations of attunement, rather than the primary bid for relationship" (Badenoch, 2008, p. 6). It is not about having a conversation with someone's mind, but with their bodymind. Therefore, we avoid analysis, judgment, interpretation, and advice-giving. Instead, we direct statements or questions to the body to see how it responds by tensing or releasing, breathing freely or holding a breath, and other signals. Clients also learn how to listen to themselves in this way: to notice sensations and signals from inside, to let them inform their conscious mind.

Practitioners also encourage clients to name their experience, partnering to find a vocabulary, which often is metaphorical. When clients are new at noticing their physical experiences, they often hesitate to speak. From my practice as an RMB practitioner, I know when a client says, "This is going to sound stupid," a new awareness arises: they find words that exactly convey what they are feeling. But they find themselves using an unfamiliar language. As one surprised client said about her legs, "There is a *there* there!"

I teach writing classes, mostly memoir, essay, and writing to heal. In *Opening Up: The Healing Power of Expressing Emotions*, James Pennebaker (1997) reports on his research on the ability of narrative writing to produce biological change. It boosts the immune system, lowers blood pressure, relieves insomnia, reduces disease severity in arthritics and asthmatics, and so on. It also clears the mind, improves one's social life, and makes people happier. Studies on people with PTSD have shown that when the participants were able to create a coherent narrative about the traumatic events they experienced and how they felt about them, they received healing benefits. One author said, "Saying something about the memory *does* something to it" (MacCurdy, 2007, p. 34).

"The science tells us that one of the most powerful ways our brains integrate isolated neural networks is when we work to generate coherent stories about our lives. This makes sense, given that putting words to feelings calms the amygdala" (Badenoch, 2008, p. 318). Finding words for their experiences, feeling them as they tell their stories, and being contained through the touch and presence of the Rosen Method practitioner allows survivors to rewrite the scripts of their lives.

I have seen how naming an experience calms people down, over and over again. Rosen Method offers something unique in this regard: the ability to uncover the *right* words. This is because practitioners are attentive to how the words affect the diaphragm. When truth (a naming of actual embodied experience) is spoken, the diaphragm relaxes. This is how an integrated use of touch, words and attention to the diaphragm brings about transformational healing.

Part 3: Specific guidelines for RMB Practitioners Working with Trauma

I have profound respect for my training as a Rosen Method practitioner, for it transformed me such that I can function in ways that seem “counterintuitive” in this culture. I used to want to “do” and “fix;” now I am convinced that it is enough to “be with;” without judgment. The following guidelines are all aspects of allowing an organic healing process to unfold rather than trying to fix someone. Sometimes it is a challenge for practitioners to grapple with this approach, and these guidelines address specific issues that come up in the work.

Do not expect your clients to trust you, and do not think you are untrustworthy if they do not.

I have seen the relief in people over and over again, when they are allowed not to trust, and explore what they need in order to restore the ability to trust. Here is a simple example: A new client is on my table. I detect no relaxation and no response to my touch or words. After a while, I ask her what my hands feel like to her. “I don't trust you,” she says and lets out a little breath.

“You don't trust me,” I reply.

“As a matter of fact, I don't trust *anybody*.”

I notice more free breath. Her back relaxes and her breathing expands. I say, “That's right; you don't trust me. Or anybody.”

“It's such a relief to say it,” she says.

Now her diaphragm is more relaxed, she can be herself without judgment, and the session proceeds with her trusting that she can be the way she is. She does not have to stress out by having her mind argue with her body about her experience.

When people become aware that they are lying on the table with fear, I ask them to notice what fearful thing they are expecting. I was surprised the first time someone asked, “You're not going to hit me, are you?” It also surprises them that they do not know that I am not going to hurt them. I even have to state explicitly what seems ridiculously obvious: that I will not hit them, abandon them, or yell at them. It is a revelation to them that they carry these fears and project them onto the present. Because they are not being judged for being in this state, they begin to feel safe enough to open to a different experience.

Most people are reluctant to feel their emotions because they fear one or all of three things:

- 1) They will never be able to stop feeling the feeling.
- 2) They will not be able to function.
- 3) They will die.

Leaving survival patterns behind is fraught with many dangers in their minds, and you have to show them when and how it is safe. Safety can begin to be established when they hear that:

- 1) You will not let them die.
- 2) You will not let them get lost forever in their feelings.
- 3) You will not let them walk out dysfunctional.

Survivors need a practitioner who is certain they can be there through the roughest spots and see them through.

Saying these things is often not enough. The client's body has to experience enough containment to

sense they will not fall apart if they let themselves feel, so I wrap the sheets around them snugly so they feel cocooned. Sometimes I place a pillow over their abdomen so they feel protection. This allows them to let go into contacting and allowing scary feelings.

There is no such thing as a “resistant” client.

At times, a client looks unwilling to allow the experience—to either check into their own feelings or take in my presence. When this occurs, I get really curious about what needs to happen to make them safe enough or what needs to be heard. “Resistance” is the voice of wisdom: something needs to be in place before the next step can unfold. Validating the resistance and treating it as if it is a doorway helps. The resistant part usually responds to respect and curiosity and gives the client and practitioner excellent information about what needs to happen next.

Practitioners approach the client, including the resistor, as a partner in the evolution of the session, with deep respect for what is inside the individual that creates the healing. I discuss this further in the section below about choice moments. “The first principle of recovery is the empowerment of the survivor. She must be the author and arbiter of her own recovery” (Herman, 1992, p.134). This alone can be restorative to survivors.

Survivors, like most people, do not know it's possible or okay to feel contradictory feelings.

They love the father they hate. They are furious and grieve at the same time. They miss the good old days that never happened. They *know* their life is good now but they don't *feel* it. Practitioners need to name these apparent contradictions and in so doing, normalize the fact the people can be full of opposites and not be crazy. We need to make space for and embrace multiple things occurring simultaneously. That's not hard to do when we anchor people, including ourselves, in our bodies.

Practitioners need to slow down and not get caught up in the clients' “fighting” or “fleeing,” both of which can show up as doing too much.

During my training to become a Rosen Bodywork teacher, my teacher asked if I'd like to try leading a part of an introductory workshop on my own. I hesitated before I said “yes,” and she noticed it. That's when I discovered that I was actually quite scared to do it, but of course would do it anyway. She offered me the radical idea of waiting until I was more at ease about it. This absolutely contradicted my whole survivor approach to life: You go forward shaking in your boots and you don't let a soul know you're terrified. For me, it was a memorable lesson in not pushing too far too fast.

Some survivors are stoics, at least the ones that need solvent instead of glue. They either do not feel, even their bodies, or they are in extreme pain without making a peep about it. They don't expect their pain to ease, so inviting them to let go and relax, to be held and emotionally nourished is not something to which they can easily comply. Never having had such an experience, they need to be guided and invited towards letting in the practitioner's touch. Often, they try to be “good clients” and let you touch them without any sense of how to let the touch help them. They may think the agenda is to ignore their negative or positive responses to contact— which is, of course, an unconscious survival pattern—and get on with the session.

The practitioner's task is to bring awareness to every little step along the way. If a hand on the back causes the breathing to shorten or stop, that's what you notice. If lifting it off helps someone to breathe,

that's what he or she gets to notice. If they can let themselves explore your hand and their fear at the same time, they can actually work through the fear and discover a new possibility. But the practitioner must not be fooled into climbing on board their "let's go get the trauma" train. Slow down. Pay attention to touch, connection, and safety before you go anywhere else.

Practitioners need to tolerate and affirm even strong "negative" feelings like rage, despair, shame, and self-loathing.

Feelings do not necessarily come forward when someone is remembering their trauma story or telling it. They do come forward when clients interrupt their survival patterns. For example, when you stop blaming yourself, you can start to get angry. When you stop fantasizing a rosy future instead of enjoying the wonderful life you have already created, your despair lets itself be known. When you break your silence, tears come. At this point, clients may feel like failures, asking, "If things are getting better, why do I feel worse?" Explain that the pattern was designed to keep feelings at bay, so now that they're freer from it, feelings can surface and have their beginning, middle and end.

The practitioner has to be comfortable with strong, distressing feelings. It can take a long time for a survivor to let himself or herself have the rage that would be the normal reaction to the injustices they have endured. When they can finally feel it, express it, have you engage with it - a simple pressure of hand-against-hand as they lie on the table is enough - then they begin to find their power. This feeling matches reality; it's appropriate and accurate. It's part of landing on solid ground.

When a client feels despair, allow him or her to feel it, in the right context. Despair is part of the original experience, and it has to be felt and named just like the rest of it, so welcome it. I will never forget the huge relief on Mary's face, and in her breath, when I blurted out, "*Of course* you feel despair. And *someone* has to let you feel it." You have to welcome everything no one ever let them feel before - everything no one ever cared about. Of course, when they ask you if their suffering will ever end, tell them why you think it will (See Box 1).

Box 1: Counterbalancing Despair

Reasons you may give for being certain that survivors will recover:

- you understand the neuroscience of healing and share it with them
- you have seen other clients (and yourself) get over it
- you can remind them of their own moments of freedom
- you trust the process and you will be with them every step of the way

You can tell them to go ahead and have the despair while you maintain the conviction that there is something more powerful within them that will not stop until they are whole.

Another difficult emotion to tolerate is shame. It used to fluster me, because it is so illogical. Any overwhelming event - a tornado, a gas explosion - can make us feel insufficient against it, because, in truth, we are. Our culture lives by such a myth of invincibility that we end up feeling ashamed of normal human

frailty. "Shame is a response to helplessness, the violation of bodily integrity, and the indignity suffered in the eyes of another person" (Herman, 1992, p. 53). When people understand the nervous systems' programmed reaction to attack, which can include involuntary immobilization, they can see that they were not being weak or cowardly; their inherent self-defense system put them in freeze mode. Too many rape victims blame themselves for "not fighting back" when they were in a biologically induced state intended to help them survive.

Some survivors actually believe that they are weak, defective or at fault if they feel or show hurt. It does not matter what hurt them: verbal mistreatment, a broken bone, or illness. Something is wrong with them if it bothers them. I understand this in the case of sexual abuse, during which they absorbed heavy doses of their perpetrator's shame and penetrating arousal. But I have been surprised at how panicked or mad at themselves survivors get if they feel any discomfort, even around current injuries or surgeries. Essential to addressing this is the Rosen Method process of supporting people to be with what IS, without judgment. Survivors do not allow themselves to be human, but when they can return to just being in their bodies, it's harder to argue that a body should not hurt when it gets hurt.

Shame also develops when the parent's response to a child's needs is more in service of the parent than the child. I suspect this can be especially true if the child's need was to have a helpful response to their trauma. If your daily needs are an annoyance, or you are crying because you are traumatized and your caregiver turns away, the conclusion will be that you must not matter. You may even get punished for bothering them. Meanwhile, your nervous system is in a distressed state with nowhere to go. "If this dynamic is repeated often enough, the synaptic strength of the neural nets comprising the state of shame increase to the point that it becomes a trait, an accepted and expected part of this person's self-perceived identity" (Badenoch, 2008, p. 107).

Shame is not simply a feeling we can choose not to feel. Whenever a client is in shame, I express firmly my great respect for them and encourage them to let the shame be there. I welcome shame without buying into it. Secretly, I am thinking: *let's see how long it will last in this atmosphere*. I know that love heals because I know about how oxytocin works.

Shame can lead people to believe that they are truly *bad*: *vile, disgusting, evil* are some of the words I have heard. It's difficult for a practitioner to listen to this kind of self-abuse without wanting to argue about it to convince them otherwise. Once, I was holding a client's arm when I asked her what it felt like. She spit out, "A piece of shit." My brain did not know what to do with it. Thank goodness for my Rosen Method training: I kept touching her in a loving way and said sweetly, "Oh, I'm touching a piece of shit." She actually relaxed; from that session on she began to trust me.

Self-critical thoughts are an excellent mechanism for distancing from the self and shutting down. Survivor clients will say these terrible things about themselves in all sincerity. When you get them out of their heads and into their experience, they can discover that these thoughts come in when a scary feeling is just under the surface. Clients need to learn not to believe these thoughts but to appreciate their function. Then they can choose between getting curious about what they are feeling, or bashing themselves to maintain the status quo. *You can not talk people out of these beliefs and behaviors, even when they wake up to their origins. The disconnection has been wired in by physiological changes that happened or happen during trauma. The bodymind and the entire nervous system have to change for trauma symptoms to heal.*

The key to processing any of these emotions we would love to avoid—utter despair, shame, wishing oneself dead, or believing oneself to be evil—is one simple thing: all you have to do is invite them to have the feeling and touch them where it's happening. Self-loathing + contact = relief. You don't have to solve anything.

Practice empathy and resonance without merging.

A Rosen Method practitioner's training conveys and focuses on qualities that trauma survivors need. Whenever I give a lecture-demonstration, someone in the audience inevitably asks how I shield myself from the client's "negative energy;" how do I keep from being affected by their "stuff"? The question never quite made sense to me until one person with whom I demonstrated gave the answer: "We were connected, but she was her and I was me, and I knew it."

Yes, empathy doesn't mean getting enmeshed or triggered. Although practitioners-in-training learn a particular set of skills - how to touch, how to observe and track, when and how to speak - our main learning is how to be present to the client and ourselves at the same time. No one can truly facilitate the healing of clients caught in trauma symptoms by going through a set protocol one has memorized. One has to really be there in each unfolding moment. We cannot even perform the skills if we have not healed from limitations to our own embodiment. Our nervous system helps to calm theirs, so we have to be in a state of relaxed awareness, active engagement, and open curiosity.

A therapist who is not aware of how his or her own body reacts to (i.e., resonates with) the fear, rage, helplessness and shame in another person will not be able to guide clients by tracking their sensations and navigating them safely through the sometimes treacherous (albeit therapeutic) waters of traumatic sensations. At the same time, by learning how to track their own sensations, therapists can avoid absorbing the fear, rage and helplessness of their clients (Levine, 2010, p. 42).

Therefore, RMB training mainly focuses on restoring our own ability to stay present. As Marion Rosen said, "On the whole, it is not so much *what we do* to patients as *who we are with them*" (Rosen, 2003, p. 21).

Educate your clients about what you know about the neurophysiology of trauma and recovery.

It makes a huge difference for someone to know that their suffering is not something inherent they simply have to endure, but a result of experiences that they can process. Give your clients information about how the bodymind heals. This provides orientation and relief in many ways:

- First, they become aware of the possibility of not blaming themselves for being unable to think their way out of it, or not "getting over it" sooner.
- Second, the knowledge of how the body heals reassures them that there is hope in the process.
- Third, it provides a language to describe or explain their experiences.

Knowing about neural networks answers the question, *Why can't I feel safe when I know I'm perfectly safe?* It answers the question, *What's wrong with me?* It can interrupt patterns of thinking that perpetuate the client's suffering.

Forgiveness?

In cases of abuse, many people think they have not healed if they have not forgiven, or that they are bad if they can not forgive. They try to get from suffering to forgiveness without any of the necessary steps in between. The first step is to be free of being ruled by the trauma; in other words, the restoration of the nervous system. It would help if the perpetrator could say, "I'm sorry, please forgive me" and mean it, and continue with offering some sort of restitution. Many parents can do this for mistakes they've made; parenting is hard! But there are abusers I consider so unconscious and unhealed from their own traumas that they persist in cruelty and injustice. Changing would require many years of their own therapy, and so the mistreatment continues. When confronted, perpetrators often act like they're the victims and heap on more abuse. "Genuine contrition in a perpetrator is a rare miracle. Fortunately the survivor does not need to wait for it. Her healing depends on the discovery of restorative love in her own life; it does not require that this love be extended to the perpetrator" (Herman, 1992, p. 190).

I doubt that it is possible or desirable to forgive people who continue to deny your humanity and have done nothing to earn your forgiveness. However, survivors do need to let them go. They need to take their stand, name the abuse, say 'no' to it, and walk away from any further attachment to people who mistreat them. This is hard, because sometimes this means they are giving up the dream of having family, and of redemption for their family. They have to face their grief and loss. After years of hard personal work, I saw my client Mary begin to do it - get grounded within herself and just let them go. Let go of forgiveness, let go of rage, let go of wanting a better outcome. She got so much more of herself back, I actually saw her stature grow.

Part 4: Seeing Results

Experience taught me some things I did not expect when I began my practice. I did not expect to find clients treating themselves the same way they were treated when trauma symptoms were first laid in. I did not expect how often their road forward involved backtracking and re-finding already discovered routes. And I did not expect the profound depth of goodness, power and "connection to something larger" (as Marion Rosen put it) that by necessity matches the depth of hurt people have experienced. The following section describes the nature of the moments that produce change.

Freedom from survival patterns, not from trauma memories

A few years into my practice, it occurred to me that my task is not primarily to engage with my clients' traumatic pasts; *it is to help free themselves from the current survival patterns that resulted from their traumas.* What continues to hurt them is doing the very things they did to survive. They had to find ways to save their own lives or psyches, so they continue to cling to these behaviors for dear life; they even identify with them, as "That's who I am". And these patterns keep them scared, disempowered, and hopeless. When clients get safe enough to start giving up rigid behaviors, this restores what was lost: the sense of agency in life, trust in the world, and the ability to enjoy life.

I spend more time engaging with the survival patterns, which are the very barriers Marion Rosen referred to when speaking of muscle tension, than with the memories themselves. When we are far enough along in the process, it becomes clear that *they have to stop trying to save their lives.* In my mind, this means

they have to stop abusing themselves.

Most of my clients have experienced childhood trauma. How did they figure out how to survive? They adopted the behavior of those around them, which could have included those who abused or neglected them! Children absorb what is modeled to them in an embodied process. I think some common symptoms of PTSD are these mindless behaviors the client copied. This insight came to me when a client came in for an eating disorder, years ago. She described how her mother had treated her, and then I saw her treat her own body the exact same way: ignoring how it felt, trying to control everything about it, and being very critical. When I reflected this to her, she immediately understood. When she returned the following week, she reported what she had experienced for the first time: she had noticed when she was hungry or not, had offered herself food when hungry, and felt affectionate toward her body.

I've derived the following list of behaviors from my clients' reports on how they were treated by their families. In the face of abuse and/or neglect, "caregivers" generally:

- deny the trauma has occurred,
- minimize the trauma, acting like it was no big deal,
- tease or make fun of the victim if they show that they are upset by the mistreatment,
- tell those they hurt that they were the cause of their behavior,
- punish or threaten the child for talking about it,
- are so good at acting like nothing weird was going on that the victim was immersed in their trance of silence and denial. The thought of naming the elephant in the room never even occurs.

In order to keep going, survivors:

- pretend they are not "freaking out" when they are,
- do not tell, even the people closest to them, when they are suffering, having a flashback or intrusive thoughts. They just don't want to be seen as weak, crazy, or needy,
- ignore their physical pain,
- feel ashamed that they bleed when they're cut, literally and metaphorically,
- berate themselves for having overwhelming feelings,
- do not believe / trust their own memories,
- are afraid they might be abuser's themselves, even with absolutely no evidence of the possibility.

These behaviors were adopted to survive, and they continue to the present moment. As Rosen practitioners, we can help clients become aware of these behavior patterns and that, although they were created for survival at the time, they do not have to continue in the present. This gives the clients an opportunity to interrupt the patterns so that healing can occur. When clients stop relying on one of these patterns, that's when they can feel their feelings and make new choices.

Turning points

It will likely take some time to work through enough of the above issues before the client comes to 'a fork in the road.' This is the moment that feels like life or death, or possibly death and death. On one hand, the client is deeply suffering from their survival patterns, which are sometimes literally killing them. On the

other hand, what happens if they give up survival and actually try living? There can be an immediate sense of annihilation, falling into a dark pit, or just plain impossibility. They know what to do - take in your contact, stop believing the internal criticism, reach out - but they do not know how to do it. What works is for me to tell them that they are okay, all they have to do is notice my hand and my presence, and wait! They do not know how to feel what they feel, whatever that may be, but I tell them something inside them does know. All we have to do is pay attention and be curious about it.

We often use the words "attention" and "curious" in RMB. They are central to healing from trauma; that is why we use them so often. As part of the safe container provided by the practitioner which helps form new neural pathways, "The focus of attention is the route to specifically activating regions of the brain and then linking them together" (Siegel, 2012, p. 10-2) thus promoting integration. "... Curiosity [is] one of the prima facie 'antidotes' to trauma. Curious exploration, pleasure and trauma cannot coexist in the nervous system; neurologically, they contradict one another" (Levine, 2010, p. 175). When we are **paying attention with curiosity**, we are allowing the cortex (the thinking and choosing part of the brain) to notice the sensations, images, movements, and emotions of the limbic brain, the brain stem, and of course, the body. "The cortex can help us reflect on these subcortical processes and offer us the opportunity, with awareness, to create choice and change... this is the power of the mind to shift how the brain may be ruling our lives" (Siegel, 2012, p. 12-3).

For me, it takes some discernment to know if a client who is persistent in their avoidance of feelings is simply stuck in a pattern or is actually self-regulating in a useful way. Clients are so afraid of losing control and actually feeling their deepest feelings that they half-convince me that they will indeed become dysfunctional. One tear trickling down the face can seem like a total meltdown to them. Again, this narrow window of tolerance was neurologically set up in childhood, so it's not exactly a choice they are now making. I proceed carefully, but I do not gloss over the moment they are choosing to shut down. I help them notice it, name it, and tell them this is a choice moment. It is the moment that they feel like they are going to die if they let themselves feel. I am serious with them about checking inside and making the choice; I am not the one who says what should happen in this moment. Of course, this adds to their empowerment over their own process! (See Box 2).

If they are in what looks like intolerable pain, that is when I move in and make sure they are aware of me, and of being safe and loved. If they have disappeared somewhere into dissociation, I make them stop, bring their attention to the room and the present moment. I think this has happened only a handful of times in the past 24 years. Most of the time, the awful session in which they dip their toe into the depth of their pain brings a subsequent moment of insight or greater freedom.

Box 2: Choice Moment

Avoidance of feelings: stuck in a pattern or self-regulating usefully?

Bringing awareness to the moment:

1. The client can continue to hold his breath, clench, ignore your contact, go into thinking
OR
2. let go of those behaviors and direct his attention to where feelings are stirring
AND to being held in a safe container.

The practitioner does not determine which to do.
The client makes a conscious choice. The practitioner affirms it.

Marion Rosen was aware that the barriers to authenticity were embedded in the body in tight muscles, constricted breathing, and so forth:

When practitioners work with patients, we use our touch first to bring awareness to the tense muscles. Our aim is to make it possible for these chronic tensions to relax... What happens emotionally is that patients become aware of their own contribution to the limitations they have imposed in their lives. With that they come to a place of choice that allows their actions to be different...they can open up and choose to show themselves: their ability to love, their creative powers, and their thinking ability...This process is not intellectual and only appears from within when allowed to emerge" (Rosen & Brenner, 2003, p. 20).

I am awed by the courage it takes to face 'the fork in the road' and choose a new way. When clients then choose to speak, or to feel, or to express, they choose to stay instead of fleeing physically or psychically. They do the opposite of what all their "instincts" are telling them to do, and they feel exposed and vulnerable. Yet they choose life, the present moment. They may have to shake from head to toe or cry or rage to do it, but they do it because they trust you, and you have taught them to trust something within themselves. The practitioner has remained steadfast with confidence in the process.

Highlighting beneficial results

Survivors can be so doubtful of actually healing that it helps to have the practitioner underscore the results of challenging their survival patterns. I always reflect to clients what I see and sense happening in their bodies, and ask if they are noticing, too. We linger in relaxation, the feeling of relief, the opening of a new space; they are able to experience change in their bodies. This is all surprising to them. Whoever thought that giving up the fight is what would save you?

My client "Brenda" was referred by her therapist. She actively fights feeling anything; her face and tone of voice are calm and blank, even when there is an earthquake in her belly. When asked what is going on inside, she says, "I don't want to tell, because that doesn't do anything." She says this completely innocent of the fact that she is telling - and showing - her trauma story. What she is used to is that telling makes it worse.

When I first put my hand near Brenda's diaphragm, I could scarcely believe the upheaval I was feeling. I do not know how many days she had spent like this. Truthfully, I was alarmed that maybe I could not really help her. However, I persisted in wanting to know what was upsetting her, and she did tell me a sentence or two about childhood sexual abuse. She always came back to, "But I don't *want* to tell." Nevertheless, when she told, her diaphragm relaxed enough for her belly to stop bucking. This gave me the confidence to keep going. I asked her to notice her belly now, and she could indeed feel that she was calmer. We went through this routine a couple of times, but it was essential for her to become aware of the experience of feeling better when she broke her don't-tell rule. It surprised her, and she was actually smiling before she left.

When people have the wherewithal to break their own survival rules, they come back reporting strange new experiences. One woman, who was convinced that no one ever wanted to see her succeed, now reports that even strangers are supporting her new business efforts. Another actually sleeps at night and dreams that she is somehow nursing herself and the world feels whole. Another client notices the beautiful light on the frost patterns on her kitchen window and realizes she has never let herself feel this alive before. A man asks his wife to accompany him to the hospital, something he never would have done before. These changes seem to happen spontaneously and feel inexplicable to the survivor, so the practitioner, who knows the client is returning to "normal," celebrates and underscores them. This encourages them toward more freedom.

How long does recovery take?

The answer is, of course, it depends. For well-adjusted people with a single, not-too-horrific trauma, I've seen them change in one to three sessions. For people who live stable, productive lives but who grew up with multiple traumas, it can take years. Many factors make a difference: do clients have supportive relationships in their lives? Do they have purposeful work? Do other resources such as nature or art inspire them? The practitioner-client relationship is the place where they can experience safety, self-awareness, and self-agency. The more they are able to integrate these qualities into their lives, the faster their recovery will be.

For me, freedom from trauma symptoms happened "overnight" after years of personal work. I'll never forget getting off the table after a session and finding that the black-and-white world had transformed into Technicolor. My body was full of joy instead of fear, and it has mostly stayed that way. I do not know if my friends could see a difference, but my fellow Rosen Method students were amazed at the change in my posture and way of walking. Internally, the unpleasant sensations in my gut and chest that accompany terror disappeared; my subjective daily experience is wonder and gratitude. My external life changed radically - I got everything I ever wanted: a house, a husband, and work I love.

However, I have not often seen this kind of transformational moment in my clients. Instead, breakthroughs happen repeatedly over time, building awareness and the ability to make different choices. Clients can begin having forgotten what happened, or that it mattered, or what its consequences are today. Whole chunks of a life can go missing, or clients can forget something they discovered in last week's in session. Over and over again, I am taken by surprise when a client comes in talking and behaving as if the breakthrough session we had last time had not happened. She *forgot* she did not have to be alone. Or, she *forgot* that the reason she hates church today is because a priest abused her 40 years ago.

People will tell you things very clearly and then act like they never said it. Or, that they never

connected that incident to the current problem. I have learned that I cannot assume that progress always moves forward from the same point. I cannot assume that the client comes in aware of what we both knew last week. Sometimes, they have to learn the same lessons over and over before they emerge from the fog of dissociation. However, I have learned that this process always leads to uncovering another layer of work and healing. A phrase the client repeated again and again (that we thought we understood) will take on a new meaning. An aspect of the trauma comes into focus and explains symptoms that were mysterious.

Week after week, they report small triumphs. The woman whose body was covered with scars wears her bathing suit to the public pool. One person, the only one in her family without a room of her own, goes home from a session and claims one. Depressions lift; back pain disappears; people stand up to abusive bosses. It took Mary many years to break her own survival rules. She began to tell her husband when she was “having a hard time” in a flashback or “relive.” She began to believe that I was real, that I understood, that I was committed to her well-being. She is returning to herself as her own authority.

The healing arc, or perhaps *spiral* is more accurate, goes something like this:

TABLE 2: SPIRAL STAGES OF HEALING

Stages	Level of Awareness	Resulting Feeling or Behavior
unaware	Survivors don't recognize that what happened to them was trauma.	stay rigid inside survival patterns
acceptance	Over time, they begin to accept the above.	may continue to doubt themselves, but not always
linking	They start to see the relationship between current behaviors and dilemmas and previous experiences.	begin to see that their problems are not inherent or inevitable
naming	Survivors can recognize and name either trauma memories or survival patterns as such.	calms them down even if they are unable to stop survival patterns yet
self-care choices	used to be to “brave,” trying to shut down in order to participate in activities that made them suffer	refuse situations that are not good for them or trigger them (like certain movies or family events)
more embodied	experience of embodied self-awareness in the present moment more often	feeling alive, appreciating the earth, trusting people, recognizing own value, speaking up
response to memories	Memories that once triggered a full-body reaction become autobiographical memories like any other.	still have emotional responses, but these do not destroy a person's ability to stay in present time.

These stages do not happen in a linear fashion. This is not a ladder but a spiral; sometimes the movement toward healing seems to go backwards and then regain its direction. Eventually, the survivors become thrivers, even as they continue on their healing journey.

Part 5: Life after Recovery from Trauma

Because I lived with PTSD until I was 45 years old, I spent decades on a search. I thought it was a search for a way to make more sense of the world, and to contribute to its healing. I remember the feeling that my Rosen Method training and sessions were “saving my life.” Not exactly my life, but my soul, my ability to actually be myself in this world. I did not have the words, “embodied self-awareness” at the time, nor did I know that it needed to be restored. Because of RMB, I learned what being present means, what it means to have experiences without judgment or attachment, and that going deeply inside any moment - particularly painful moments - opens the doors to a profound experience of peace and well-being.

I have come to see myself as a process linked to an unfathomable array of processes. I have learned how to come back to myself when I leave. When I am home here in my body, I am safe because I'm me. From here, I look at my world and it is suffering; it is beautiful; it is kind to me. I'm not separate from it. Walking in the autumn woods one day last year, I exclaimed at the beauty of golden sunlight on golden leaves. Then I experimented with taking in what I was observing the way I do as a practitioner: through my belly, rather than through my eyes and brain. Instantly, I was walking through Myself. The Me in my skin was just a part of the Me all around. “The Self is much more than our skin-encased bodies, let alone what simply happens between our ears” (Siegel, 2012, p. 15-4). This continuity makes me part of a very large whole: very large, with energies and intentions that I am only vaguely aware of, but I can sense them when I pay attention.

I am not the only one who suspects that recovering from trauma *adds* something to one's life rather than diminishing it. This is probably less true for complex or developmental trauma, but “Research indicates that when persons who have experienced severe trauma have been compared with those who do not report trauma, positive personal changes are reported at a reliably higher level among trauma survivors” (Tedeschi, 2004, p. 5). Survivors say they wish the trauma had never happened, and yet they appreciate their development that came from their response to the trauma.

Post Traumatic Growth is not a result of the trauma itself but of grappling with survival and creating meaning. Researchers have identified five domains of growth (Tedeschi, 2004, p. 6; see Box 3).

Box 3: Five Domains of Post Traumatic Growth

1. Greater appreciation of life and changed sense of priorities
2. Warmer, more intimate relationships with others
3. A greater sense of personal strength
4. Recognition of new possibilities or paths for one's life
5. Spiritual development

Often, trauma gives survivors a mission, and they embark on changing some aspect of the world. Beyond even achieving resilience, "Posttraumatic growth is not simply a return to baseline - it is an experience of improvement that for some persons is deeply profound" (Tedeschi, 2004, p. 4).

Recovering from trauma necessarily involves spiritual growth. We need our healthy, larger Selves to be present to our hurting selves. We need the diaphragm, our "spiritual muscle" - as Marion Rosen called it - to relax. Because, when the diaphragm is free, people open to a state of deep connection to self, to the outside world, and to something much larger. This provides an experience that Albert Einstein described as "the experience of safety and rightness from which one is able to sense the interpenetration of all things. The effect of this experience is that thereafter one feels singularly at home and unafraid in the universe" (quoted in Green, 2013, p. 27).

Practicing and teaching RMB is a huge part of what keeps me feeling that I have indeed arrived in my meaningful life. Daily, I have reason to be completely engaged in what I am doing, whether it's giving a session, walking in nature, writing, or being with someone I love. Fogel calls this ability to accept and be absorbed in our own experience an "act of love" for two reasons: it "not only enlarges a person's own embodied self-awareness, but it may also enlarge the embodied self-awareness—the capacity for the fullest possible human experience—in others who come into contact with that person or their work" (Fogel, 2009, p. 278). Since childhood, I have searched for a way to make the world a better place. Although Marion Rosen developed this work as a means of personal healing and transformation, she came to see that "this work can transform family interactions, work and creative life, and the world" (Rosen, 2003, p. xiii).

Conclusion

Rosen Method Bodywork uses a unique, integrated application of touch, words and attention to the diaphragm to help clients achieve embodied self-awareness, which is essential to recovery from trauma. RMB addresses every level of a person, body, mind and soul so that they may recover all that was lost in MacCurdy's definition of trauma, including agency and meaning in life and trust in the world. Beyond restoration, healing from trauma can contribute to growth and development beyond previous levels of embodiment and empowerment.

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