Somatic Experiencing® in the Treatment of Automobile Accident Trauma

by Diane Poole Heller, Ph.D. and Larry Heller, Ph.D. Abstract

This article on the role of the body in auto accident recovery describes some of the basic elements of Somatic Experiencing developed by Dr. Peter A. Levine. Using a general clinical example to provide clarity, the following are some of the questions addressed in the article: What is trauma from an SE perspective? What is an Oasis of Safety and why it is essential never to work on traumatic material without first having established this Oasis. What's right with the client and how can you use that information to develop an inventory of resources? How does the therapist need to help the client shift back and forth between the calming effect of resources and the high activation of traumatic material? Why when working with trauma is slower faster and less more? How does the body instinctively mobilize to defend against threat using fight, flight, and/or freeze responses? How do trauma survivors get stuck in survival mode when survival energy gets thwarted and left undischarged? How does over- arousal in the autonomic nervous system become bound in the body in the form of trauma symptoms? Why can trauma not be resolved without biological completion?

We have found that the trauma recovery model developed by Dr. Peter A. Levine called Somatic Experiencing (SE) is one of the most effective tools for the healing of traumatic life events. SE is a relatively short-term, somatically based approach to the healing and resolution of trauma. We use SE as the foundation for our Auto Accident Recovery Program and find it particularly helpful in the treatment of auto accident trauma because of the special difficulties presented by high speed, high impact trauma.

SE can easily be integrated with other models but offers unique differences and specific contributions.

We will illustrate this through a clinical example. One of our clients, who we will call Marianne, came in for treatment several months ago complaining of many unresolved symptoms. On a rainy Monday morning two years previously, she had been rear-ended while waiting at a red light. Marianne reported seeing the blue van that hit her in the mirror only seconds before impact. Ever since the accident her sleep has been seriously disturbed. She often wakes up terrified and has flashbacks of loud crash sounds and feels the jolt of impact. Often distracted, she finds herself bumping into furniture and easily misplacing things. She continues to be anxious about driving and avoids it as much as possible - especially when it is raining. Marianne panics when cars pull up behind her at intersections or tailgate her on the highway, tensing and bracing as if expecting to be hit again. She constantly checks her rear-view mirror and, therefore, is less attentive to cars around her in other directions. Memory fragments of sounds and images from her accident keep resurfacing because these fragments are still too highly charged to be integrated, completed, and released.

After her accident, she was immediately take to the emergency room. She was diagnosed with whiplash and suffered various contusions. Her treatment over the next years consisted of medications prescribed by a psychiatrist for her anxiety and sleep difficulties. She visited a chiropractor for 6 months for the whiplash including neck, shoulder and back pain as well as severe headaches. While there was some improvement, many of her chronic pain ailments persisted. In psychotherapy she was encouraged to 'talk it out and get to her feelings'.

In the course of all of her treatment strategies, Marianne retold the story over and over again. She relived the experience many times and got upset every time she described the accident. Some of her symptoms worsened over time despite the efforts of well-meaning therapists. She said she felt like she was going crazy because she still felt so much fear and anxiety. She said she got angry over nothing and sometimes felt she spaced out while driving, especially on wet roads. She began to feel that her caregivers, family and friends were becoming impatient with her continuing physical complaints and obvious hyper-vigilance and nervousness in the car. She felt blamed for not healing more quickly and that she should 'get on with her life'.

Of course, not every scary situation results in Post- Traumatic Stress Disorder. PTSD occurs when a person confronts a perceived or real threat that leaves her feeling overwhelmed and helpless and unable to defend herself. As Freud pointed out many years ago, trauma results when there is a breach in the stimulus barrier and the excessive stimulus or over-arousal becomes unmanageable and out of control. This excess stimulus becomes bound into generally predictable symptoms in the body.

A basic principle in Somatic Experiencing is that trauma is in the nervous system, not in the event. The autonomic nervous system is designed to handle charge or activation or stimulus from life events and functions to help us literally digest everyday experience much like our digestive systems are naturally designed to digest lunch. We don't have to think about 'working' on the salad and then the soup or sandwich. Our bodies know how to take and absorb what is needed and eliminate the rest. The nervous system basically operates in the same way but more like an electrical system that gently fluctuates, keeping our energy levels within a manageable range. The sympathetic branch of the autonomic nervous system charges up and energizes us and the parasympathetic branch helps us discharge excess energy and relax.

When confronted with the overwhelming threat, it is as if the nervous system is wired for 110 volts and is hit with 220. Tremendous defensive survival energies of fight, flight and/or freeze are mobilized when we instinctively react to danger. The over-arousal or high activation of both branches of the autonomic nervous system can result in deregulation and often a jamming occurs that causes either flooding, or freezing/ dissociation.

Part of the problem is that when these states occur, discharge of the intense energies mobilized to meet threat often becomes thwarted. Often we just don't have the time necessary to complete them. Nevertheless, the survival energy has mobilized for fight or flight, but literally has no place to go and ends up being converted into symptoms.

Think of the thermostat in your office. You may want the temperature to stabilize around 65 degrees but in actuality the temperature probably self-regulates between 63 and 68 degrees. When shock hits the autonomic nervous system it would be like the thermostat keeping a median temperature of 65 but alternating between 0 and 130 instead- certainly not comfortable. After trauma, people often experience an alternating state of either freezing/dissociation or flooding. The client's internal thermostat becomes set at 'too OFF' or 'too ON' which needless to say is extremely uncomfortable - much like being thrown on an internal roller-coaster without signing up for it! This imbalance or deregulation helps us understand what was happening for Marianne. Her panic, anxiety and angry outbursts were

examples of sympathetic over-activation and her spaciness, disconnection and accident proneness reflect parasympathetic over-activation.

Both were occurring in her nervous system fueled by leftover over-arousal from the body' s incomplete attempts to discharge or inability to protect itself. It is important to understand this dynamic that we are obviously oversimplifying, because it implies treatment strategies that can help a client move through overwhelming material without becoming overwhelmed in the process.

First of all, it is essential to interrupt your client! When Marianne began to tell her story, we gently interrupted and said to her, 'We eventually want to hear the story of what happened to you, but first we have a different question for you. . .can you remember the first time you felt safe after the accident?' Marianne, surprised by this shift in focus, reported that she first felt safe when she saw her husband, Rick, come for her in the ER. We helped her expand her awareness of how this sense of safety felt in her body. She reported feeling relief, warmth in her arms and legs, and a calming sensation. We noticed a significant shift from shallow breathing to deeper belly breathing. All of these signs show that the parasympathetic branch of the nervous system is gently beginning to facilitate discharge.

This technique is important for two reasons. First, it establishes in Marianne's awareness that there is an 'after' because so often when people have been traumatized, they experience it as if the trauma were certain to happen again, as if it remains ahead of them. They are not really aware that it is, indeed, over. The second reason is to help clients perceive the body's capacity to switch to a relaxation response out of the high activation that has been taking over their life. Some clients have not felt safe since the accident. We need to help them find another resource previous to the accident that will trigger a relaxation response.

Often clients feel an urgency to tell the story as an attempt to finish the experience, but the nervous system is already overloaded and is unable to discharge. Each time Marianne retold her accident story her nervous system reacted by mobilizing for the threat again and created even more excess energy that increased her symptoms. We see symptoms as markers for where the body has attempted to compartmentalize leftover survival energy that has not yet been able to be discharged or released. Unfortunately the system becomes increasingly closed and the threat response internalized so that eventually the activation itself, without any outside influence at all, causes and perpetuates mobilization of defense energy and exacerbates the symptoms over time.

Because the part of the brain in charge of survival basically takes a 'memory snapshot' of elements considered part of the danger of the accident, associations to the original event fuel fears, hyper-reactivity or disconnection. In Marianne's case, the danger came from behind while driving, the accident occurred at a familiar intersection, it was raining at the time, and the sound of metal on metal during impact was terrifying. Understandably, triggers for her fears or dissociation occur when she is approached from behind especially while driving, when she sees wet roads, hears loud noises or is stopped at intersections. Our job is to help her extinguish these triggers. We explained to Marianne how her symptoms were, at least in part, related to an over-activated nervous system and that we would be tracking physiological signs of over- activation as well as listening to the specific details of her accident. We explained that we would interrupt her so that her activation would not

become too high for her, in order to help her stay present and integrate the material. We began by helping her discover her own resources, real or imagined, that would initiate a parasympathetic discharge or relaxation response internally. When she began to focus on the accident arid began to flood or disconnect, we immediately shifted her attention to after the accident was over when she felt out of harms way or safe again.

This illustrates another key concept of Somatic Experiencing called 'pendulation' or 'looping'. Looping is a technique in which the therapist helps the client move back and forth between small pieces of the traumatic material and one of the client's resources. This looping back and forth helps discharge the activation in the nervous system that emerges as the person slowly works through the traumatic event.

After establishing an initial resource, we want to continue to build an inventory of resources so that the client feels stabilized before refocusing on the traumatic material. We asked Marianne how she has gotten through difficult times in the past. She identified certain friends and family members that are a part of her support system as well as activities that help her relax such as music, biking and meditation. We also referenced other times and events in her life when she remembered feeling safe and secure.

We then had her feel what happened in her body physically when she focused her attention on these people and activities to further expand her sense of groundedness and stability much like creating an 'Oasis' for her to refer to when we began to work with the chaotic, highly charged accident material. It is essential to bring the clients' awareness to the sensation experienced in their bodies and not just imagine the resources as a creative visualization. It is also necessary and much more empowering for the client to discover his or her own resources rather than to have the therapist suggest resources for them. When activation began to build for Marianne beyond a manageable level, we asked her what she might feel would be comforting and. soothing in that moment rather than telling her to 'surround herself with white light' or to imagine herself relaxing on a quiet beach.

With a resource inventory available and stability established, we then began to focus on the trauma. Like bookends, we first started at the end and now we begin at the beginning by asking about the very first moment she realized something was wrong, before the impact. She said she had had only a quick glimpse of the blue van in the rearview mirror before it slammed into her at 35 mph pushing her into a busy intersection. This question helps identify when the threat response was initiated and will predictably hold intense activation. In this case, like so many traumatic events, there was no time to recognize or complete any of the body's natural instinctive survival reactions.

The missing resources here were obviously a lack of time and space. To give her more of both, we asked her to "freeze frame" the blue van before it hit her and to imagine moving it back as far as her body wanted it to be so that she could feel safe. We told Marianne to freeze the image of the van there. She showed signs of immediate relief and pictured the van about three blocks back. We suggested she take all the time she needed to fully look at the van that she now knew to be a threat. This helped her locate the threat and have time and space to respond to it. It also gave her advanced warning. We asked her to feel what her body wanted to do in response to the now known threat.

First she felt the desire to accelerate through the intersection to get out of the way -an example of the flight response. We suggested she try that out and feel her foot press on the accelerator and see herself get out of the way. She felt energy release down her leg and

through her foot. Once she saw herself out of harms' way, she noticed feeling generally calmer throughout her body. Unless you've seen the relief that this way of working can bring to a traumatized client, it is hard to believe how effective these techniques can be.

We returned to the blue van, still three blocks back, to see what else her body may want to do in response to it. This time, she felt angry and wanted to yell at the driver and honk the horn. We told her to feel that version of the fight response and try this survival plan. Again she felt a palpable discharge. She could see that her body could design realistic survival plans when it had enough time and began to trust her body again as well as feel the relief that comes with finding a way to complete actions and discharge pent up energy.

There are predictable biological sequences that will become evident. When something novel occurs in our environment that alerts us, such a strange noise, our threat response is often activated. When alerted, we first stop what we are doing and will usually notice a slight jolt or startle response. We then orient our eyes, ears and our body position to locate the possible threat. If we determine it is, in fact, dangerous, we then instinctively move either toward it to confront it as in the fight response or away from it to avoid the difficulty as in the flight response. Sometimes in intense, life- threatening situations, there is no time to initiate any action and we freeze or become immobile.

Later as the freeze response literally thaws out, we tremble and shake as the nervous system releases and reorganizes. Soon impulses for fight or flight will surface as a sense of mobility returns and there is the opportunity to complete them to facilitate further discharge. Interestingly enough, it is not necessary to actually make the gross motor movements of fight or flight. Simply having Marianne feel her body organize fight and flight responses and then feeling her body prepare to move or just move slightly and in slow motion, the body finds its greatest release. In most traumatic events, and typical of auto accidents, the body has little if any time to prepare and these preparatory movements are overridden. By giving the body all the time it needs, it can then relax and shake off the excess energy left from the traumatic experience. Biological completion helps unlock the jamming in the nervous system and allows the client to integrate the experience so that they can indeed move on in life and become freer of the after-effects of trauma.

By starting from an Oasis of Safety, building resources, taking only very small pieces of the traumatic material, then using those resources to neutralize the activation. By going slowly, directing attention to events before and after the impact, and working gradually toward the center, it is possible to regain a continuity of self. There is an experience of moving from fragmentation toward integration.

Clients find that they can gradually slow down and maintain an integrated awareness from start to finish throughout the accident, including impact. Then perceptually, the accident can move from seeming to be ever present, or fixated in the future back into the past where it belongs. Symptoms diminish. Triggers of fear, panic and anger are extinguished as continuity of self is re-established and the accident is experienced as truly over. With six months of Somatic Experiencing treatment, many of Marianne's phobias, as well as most of her physical and emotional symptoms, were resolved.

References

- Heller, Diane and Laurence. Crash Course: A Self-Healing Guide to Auto Accident Trauma and Recovery, California, North Atlantic Books, 2001
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Biographies

Diane Poole Heller received her Ph.D. in Higher Education and Social Change from the Western Institute for Social Research in Berkeley, California. She is a Licensed Professional Counselor. As a member of the faculty of the Foundation for Human Enrichment, Dr. Heller has taught courses on trauma to therapists and health care professionals throughout the world.

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