Healing the Trauma Body

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We have all been traumatized, some more than others. Trauma is not special … it’s part of the lived experience. During my thirty-three years of clinical experience, I have witnessed that traumatic wounding is at the heart of most human suffering and that everyone in the field of structural integration (SI) needs to know how to work with it. My hope is that this article will evoke a deeper understanding of what trauma is while providing strategies for its resolve.

What is Trauma?

Trauma is a Greek word for injury, wound, pierce, damage, or defeat. Sigmund Freud, in 1914, defined trauma “… as a breach in the protective barrier against stimuli leading to feelings of overwhelming helplessness.”\(^1\) Susto is an ethnomedical condition common to Latin America and is described as an illness or ‘fright paralysis,’ also known as soul loss resulting from a traumatic experience. We have all witnessed the ‘deer in the headlights’ frozen look or experienced feeling ‘scared stiff.’

Kinds of Trauma

**Generational trauma** may be passed from generation to generation in self-perpetuating cycles that are hard to break. It can be transmitted by social learning in the family and community, and growing evidence shows that it may also be inherited epigenetically in the expression of the genes and from before conception in genomic imprinting. Family Constellation Therapy developed by Bert Hellinger and shamanic rituals from various indigenous cultures may provide an opportunity to liberate oneself from the suffering of the ancestors.

**Conception shock**, or first union, occurs when the sperm (issues of the father) penetrates the ovum (issues of the mother) creating the potential for a new human identity. One’s conception could be unwanted by both or either parent due to a myriad of circumstances.
Implantation trauma, or second union, occurs seven to nine days after conception as the ovum attempts to ‘attach’ to the uterine wall. The degree to which the mother desires a child (how much her body aids and/or resists implantation) and any attempt to abort the embryo will leave an imprint on the whole being.

Intrauterine trauma can take place during the full term of uterine life (nine months). The mother’s psycho-emotional life directly imprints the developing embryo/fetus for better or worse as does any toxic or noxious substances that she ingests.

Birth trauma is damage to the tissues and organs of an infant caused by mechanical forces during childbirth, often accompanied by impaired blood circulation and organ functioning as well as hypoxia. The most frequent and significant birth injuries are to the skull, brain, and spinal cord, the severity of which usually distinguishes spontaneous birth traumas from those of an obstetric nature such as injuries from the use of forceps or vacuum extraction.

Attachment disorders take place during the pre- and perinatal phase of development. This is also known as the ‘maternal attachment period’ when the developing human requires the full attention of the primary caregiver for survival (last trimester until two years of age).

Emotional, psychological, and physical traumas are persistent throughout one’s life.

Soldier’s heart, also known as war trauma, leaves the warrior with symptoms of post-traumatic stress disorder (PTSD), anxiety, cognitive impairment, etc.

What Causes Trauma?

As Freud said, the cause of trauma is a breach in the protective barrier against stimulation. What is this protective barrier that Freud refers to? According to traditional Chinese medicine (TCM), all living bodies generate an external field of energy called wei chi, which translates as "protective energy." The definition of wei chi in medical qigong is slightly different than that of TCM. In classical TCM texts, the wei chi field is limited to the surface of the body, circulating within the
tendon and muscle tissues. In medical qigong, however, the wei chi field also includes the three external layers of the body's auric and subtle energy fields. This energy originates from each of the internal organs and radiates through the external tissues. There the wei chi forms an energy field that radiates from the entire physical body. This field of chi protects the body from the invasion of external pathogens and communicates with, as well as interacts with, the surrounding universal and environmental energy fields. This wei chi is also referred to as the superficial fascial network and called the “whole body immune system” and is the transitional phase where energy is becoming matter, and matter is becoming energy.

Dr. Rolf was very much aware of this field of relationship in the body. “Rolfing® [Structural Integration] is an approach to the personality through the myofascial collagen components of the physical body. It integrates and balances the so-called ‘other bodies’ of man, metaphysically described as astral and etheric, now more modernly designated as psychological, emotional, mental, and spiritual aspects.”

Common to all types of trauma is this “breaching” of the protective envelope and leaking out of our vital nature and stream of consciousness. Dr. Peter Levine refers to this fracturing as the trauma vortex, and you may read about it in his books *Waking the Tiger* and *In An Unspoken Voice*. What Levine and others have stated is that trauma is in the nervous system and not in the event or the story of what happened.

**Polyvagal Theory**

The polyvagal theory, born from the research and writings of Stephen Porges, Ph.D., is a new understanding of the autonomic nervous system (ANS). His groundbreaking work provides an elaborate mapping of the psychophysiological systems that govern the traumatic state and illuminate the pathways for recovery and integration from these deleterious states of mind and body. Prior to the polyvagal theory, we had been taught that the ANS was organized by a paired antagonism between the sympathetic and the parasympathetic nervous systems, which functionally competed by either increasing or decreasing activity of neurophysiological states. Porges proposes:

Phylogenetically, a hierarchical regulatory stress-response system emerged in mammals that not only relies on the well-known sympathetic-adrenal activating system and the parasympathetic inhibitory vagal
system, but that these systems are modified by myelinated vagus and the cranial nerves that regulate facial expression which constitute the social engagement system. Thus, phylogenetically, self-regulatory development starts with a primitive behavioral inhibition system, progresses by the evolution of a fight-flight system, and, in humans (and other primates), culminates in a complex social engagement system mediated by facial gestures and vocalizations.3

The most primitive of these regulatory systems is over 500 million years old stemming from its origin in early jawless fish species. Its primary function is immobilization, metabolic conservation, and shutdown. This is the unmyelinated dorsal vagus, and its target of action is the viscera. Next in development is the sympathetic nervous system (300 million years ago), mobilizing the organism by activating the adrenals providing fight or flight by way of the limbs, as witnessed in amphibians, frogs, sailfish, etc. The last-developing system (90 million years ago) exists only in mammals, with its greatest refinement in primates, mediating complex social and attachment behaviors. This system is neuroanatomically referred to as the “smart vagus” and is linked to the cranial nerves regulating the muscles of the face, throat, middle ear, heart, and lungs. It is the myelinated ventral vagus and is associated with emotional intelligence.

Our nervous systems are continuously evaluating potential risks in the environment — a non-conscious detection system termed neuroception by Porges. The detection of a person or circumstance as being safe, dangerous, or life-threatening triggers neurobiologically determined prosocial or defensive behaviors. In essence, Porges has defined two defense systems, fight/flight or freeze — a great contribution to all of the social sciences but particularly of importance for somatically based therapies such as Rolfing® SI. Practitioners of bodily-based therapies witness states of hyperarousal (sympathetic nervous system) and hypoarousal (dorsal vagal parasympathetic nervous system) in their clients everyday. Here’s a general schema of the two:

**Hyperarousal**
Sympathetic NS
“Charged” (rigid)
Adrenals
Controlling
Psyche’s way of saying: “This a lot . . . I must hold on!”

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1. Phantom
2. Porges
3. Porges

**Hypoarousal**
Dorsal vagal parasympathetic NS  
“Undercharged” (flaccid)
Immobility – frozen
Numbness – ‘waxy flexibility’
Dissociation
Death-feigning
Escape when ‘no escape’
Resignation
Psyche’s way of saying: “This is too much . . . I give up!”

There are many factors determining whether a person will go into hyper- or hypoarousal. Obviously, the intensity of the stress (i.e., is it dangerous or life-threatening) is one element; but perhaps most critical is the person’s ‘window of tolerance.’ Dr. Daniel Siegel proposes that between the extremes of sympathetic hyperarousal and parasympathetic hypoarousal is a ‘window’ or range of optimal arousal states in which emotions can be experienced as tolerable and experience can be integrated. Exposure to threat or trauma challenges one’s window of tolerance with ANS-activated states accompanying animal defense survival responses such as fight, flight, or freeze (submission). Once the threat has passed, many victims stay in their hyper- and hypoaroused defensive states. Thus, traumatic experiences result in an array of cognitive, emotional, and physical symptoms: fear, shame, rage, terror; numbing of feelings and body sensations, overactivity of the stress response, and painful and negative beliefs about oneself. With a dysregulated nervous system that can’t modulate heightened emotional states or states of depression and numbness, a person reports an inability to tolerate arousal without being overwhelmed. Somatic responses become frozen, collapsed, or driven and action becomes impulsive or impossible.

**Trauma and Loss**

Trauma leads to loss. What do we lose? Firstly, we lose our instinct. Intuition has its seed in ancestral instincts for survival and adaptation. Our ancestors’ responses had to be instantaneous; original instincts (now identified as intuition) were based on a rapid-access fast-track system separate from conscious thought and unencumbered by hesitation and doubt.

In cases of early traumatization, one may lose the ability to say “no” and experience difficulty defining personal boundary space. Recall my previous
analogy to the wei chi . . . a leaking out of vital nature, a breaching; the person has lost the ability to protect him/herself. In addition to losing touch with instinct and the ability to say no, the traumatized person loses his/her sense of gut knowing – that settled feeling in the belly of personal safety – that everything will be okay and becomes chronically disoriented and confused while being caught between feelings of hyper- and hypoarousal.

Perhaps most importantly, a traumatized individual has lost his/her felt sense. The felt sense is the medium through which we experience the totality of sensation creating an integration of what has happened. It’s how we know that we are alive, a whole perception of where we are in our life at this moment. It’s a super-consciousness that’s non-cognitive. It arises out of the more primitive brain structures that are associated with a person’s early relationship with the mother or primary caregiver – the maternal attachment phase. A leading proponent of this relationship was Dr. Donald Winnicott, a pediatrician and psychoanalyst who described the mother’s ability to create a “holding environment” in which the infant was contained and supported in his/her experience of life. One of the elements Winnicott considered could be lost in childhood was what he called the “sense of being.” For Winnicott, the sense of being is primary, the “sense of doing” an outgrowth of it. The capacity to "be,” to feel alive . . . the baby's lifeline, what Winnicott calls its "going on being" is essential. This holding environment is ruptured with traumatic wounding.

**Affects of Trauma**

What is affected by trauma? The whole organism! Merriam-Webster’s definition of *organism* is “a complex structure of interdependent and subordinate elements whose relations and properties are largely determined by their function in the whole.” It's not just muscles, bones, ligaments, blood, or fascia. It includes brain tissue, thoughts, beliefs, ideation, self-image, attitudes, and worldview – body and mind, emotions, intellect, and spirituality. In essence, trauma creates a ‘fracturing’ of our coherence in navigating life and leaves us fragmented and disembodied.

**Resolving Traumatic Wounding**

Structural Integrators have a special opportunity in providing resolve from traumatic wounding for our clients. The father of somatic psychology, Wilhelm Reich, was a protégé of Freud; unlike other psychodynamic analysts who
focused on the ‘talking cure,’ he was most interested in the underbelly of relationship between patient and analyst. He was emphatic that there were two bodies/two animals in the treatment room and that the human animal is what is prone to psychopathologies (not the human mind). He used breath work and manipulation of the patient’s body to elicit strong emotions and release neurotic behaviors, a way of working with ‘shape to affect state.’ He was well aware that body armor or defenses were at the root of psycho-emotional dysfunction; through his methodologies, many patients were liberated from their chronic suffering. He stated that one’s body shape indicated how the person handled or organized his/her charge . . . meaning his/her instinctual drive and life force, which he called “orgone.”

I’m sorry that Rolf and Reich did not meet and collaborate on their findings. Although Rolf emphasized the need to organize human structure (form), she did not elaborate on the psychological and emotional history that would arise from her manipulative techniques. Furthermore, classical Rolfing work oriented toward mobilizing the tight and bound structures (hyperaroused) with little, if any, guidance on how to work with the numbed and collapsed structures (hyporaroused). In my early days as a practitioner, I was overwhelmed with the issues that arose in my clients that my Rolfing training had not prepared me for – strong feelings and emotions, memories, thoughts, fantasies, body contorting, involuntary gesturing, etc. I needed help and sought support and guidance from Levine.

A practitioner’s ability to resolve trauma requires one to know his/her own states of hyper- and hypoarousal. This view is supported by Rolf’s saying, “The Rolfer’s ultimate laboratory is his/her own body.” My masters’ thesis “Intersubjectivity and the Practice of Rolfing” examines and confirms that the Rolfer is working within an intersubjective field of relationship, whereby the practitioner is feeling the client as the client is feeling the practitioner. A primary component of this alliance is the emotional bond that is formed and the regulation of feelings between client and therapist. We can no longer objectify our clients as needing fixing but rather establish a rapport of explicit and implicit communication, whereby there is a co-regulation of dysregulated states.

The idea of co-regulation has its genesis in the study of mother/infant behavior and is described in the maternal attachment literature as where the caregiver provides safety, containment, attunement, and resonance for the infant’s sensory and feeling needs so that it may go on being. Dr. Allen Schore, one of my mentors in graduate school and a pioneer in the field of psychoneurobiology (mind/brain/body), and Siegel, a pioneer in the field of interpersonal neurobiology
(intersubjectivity), concur that the regulation of emotion is the essence of self-organization. Siegel further elaborates on this notion when he says, “Lack of mental well-being may often be a result of emotion dysregulation.” According to their findings, a therapist (practitioner) serves as an external psychoneurobiological regulator of the client’s disavowed body/mind states. In simple language, we as Rolfers ideally empathize with our clients while providing a co-regulatory field of relationship: “Perhaps the most striking evidence of successful empathy is the occurrence in our bodies of sensations that the patient has described in his or hers.” The ability of the practitioner to empathize with the client’s highly charged emotional state and/or a state of dissociation and numbing collapse may not be easy. That is why I urge all those in the helping professions to do their own therapy, to know their inner states of suffering expressed as hyper- and hypoarousal. Otherwise, a practitioner will become confused, disoriented, and activated in working with dysregulated affective states of their clients. Remember: “. . . it is the response, not the traumatic event, that is critical.” Healing and resolving traumatic wounding requires a ‘witness,’ one that can meet the person and guide him/her through his/her survival mechanisms. I contend that trauma theory is a regulatory theory.

Trauma provides an opportunity, a re-direction from the path we were walking. Levine describes a portal, the trauma vortex, one needs to go through in order to attain the transformative influences that trauma can provide. “Trauma sufferers are so frightened of their bodily sensations that they recoil from feeling them. It is as though they believe that by feeling them they will be destroyed or, at the very least, make things worse. Hence they remain stuck.” The key to unlocking one’s ‘stuckness’ requires one to feel the physical sensations of paralysis without becoming overwhelmed by the fear associated with the immobility. This must be done gradually, in a titrated manner, so that the person can surrender to the underlying feelings that lead to transforming trauma. “In addition, the ‘awe-full’ states of horror and terror appear to be connected to the transformative states such as awe, presence, timelessness, and ecstasy. They share essential psychophysiological and phenomenological roots.”

Prior to my plenary talk at the Rolf Institute®’s 2011 Membership Conference, Levine said to me, “Let’s not forget to remind them that Dr. Rolf gave us a blueprint, a map, of getting the person’s chassis, their frame, balanced, connected, and unified with the field of gravity so that they may have a container to tolerate more of what may be arising at any given moment.” Good Rolfing work creates more space in the body, providing an opportunity for the client to meet his/her issues of holding. It is natural for feelings, sensations, emotions, and memories to arise during a session. What can a practitioner do to meet these unfolding processes? I suggest following these simple guidelines:
Meet clients where they are. . . Don’t try to change them or fix them!
Give clients space while providing a holding environment – a kind of mothering.
Ask at every level: “What does this moment need?” . . . And be willing to expand your window of tolerance.
Stay open. . . You don’t know where healing is going to come from!
Let go of control. . . So that power can come through.
No two sessions can be the same; know that there is an ongoing continuum of change.
The key to resolving our clients’ traumatic wounding is by guiding them to self-regulation.

There is a classical shamanic motif that embraces the death and rebirth of the old self to permit the emergence and integration of a higher-order self. The shaman knows that The Hurt of One Is the Hurt of All! I can’t think of a more poignant description of what the healing of trauma can provide than: ‘From the One to the Many and the Many to the One.

With over thirty years of teaching and clinical experience, William Smythe, M.A., is a pioneer in the fields of somatic psychology and Rolfing SI. Throughout the years, he’s taught somatic therapy and Rolfing® workshops and trainings internationally. As an early collaborator with Dr. Peter Levine, the originator of Somatic Experiencing®, Bill has a diverse resume of the healing arts. He holds a masters degree in somatic psychology with extensive training and influences from Somatic Experiencing®, biodynamic craniosacral therapy, visceral manipulation, Ericksonian hypnotherapy, and Native American shamanism. Please visit his website: www.williamsmythe.com.

Endnotes

5. Siegel, D.J., pg. 274.
6. Havens, L., pg. 46.
7. Porges, S.W., PhD., “The Polyvagal Theory for Treating Trauma.” Quote from page 4 of the teleseminar transcript.


9. Ibid., pg. 353.

**Bibliography**


