

Trauma-the Vortex of Violence

by Peter Levine, Ph.D.

Teddy

"Daddy, daddy, let it go, let it go....Please don't kill it....let it go."

These are the terrified screams uttered by ten-year-old Teddy as he bolts from the room like a frightened jackrabbit. Puzzled, his father holds an immobile tree shrew in the palm of his hand, one that he found in the back yard and brought to his son. He thought it an excellent and scientific way to teach Teddy how animals "play possum" in order to survive. Startled by the boy's reaction to his seemingly benign gesture, Teddy's father is unaware of the connection that his son has just made to a long-forgotten event. It was an "ordinary" event, similar to one that millions of us have experienced.

On Teddy's fifth birthday the family paediatrician and lifelong friend came for a visit. The whole clan gathered around the doctor as he proudly showed them a photograph he had taken at the local hospital depicting baby Teddy at age nine-months. The boy took a brief look at the picture, then ran wildly from the room, screaming in rage and terror. How many parents have witnessed similar inexplicable reactions in their own children?

At nine months of age, Teddy developed a severe rash that covered his whole body. He was taken to the local hospital and strapped down to a paediatric examination table. While being poked and prodded by a team of specialists, the immobilized child screamed in terror under the glaring lights. Following the examination he was placed in isolation for seven days. When his mother arrived at the hospital to bring him home, Teddy did not recognize her. She claims that the boy never again connected with her or any other family member. He did not bond with other children, grew increasingly isolated, and spiralled into a world of his own.

Jeff

As an adolescent, Jeff gathered dead animals struck by pickup trucks and cars. He took the animals home, cut open their bellies with a knife, and removed their intestines.

At four years of age, Jeff had undergone a hernia operation. Following the surgery, the boy seemed to "snap." He withdrew from family and friends, and became awkward, secretive, and depressed.

To infants and young children, events such as these are as terrifying and traumatizing as being abducted and tortured by a grotesque race of alien giants. Without appropriate support, a child does not have the inner resources to comprehend the blinding lights, physical restraints, surgical instruments, masked monsters speaking in garbled language, and drug-induced altered states of consciousness. Nor are they able to make sense of waking up alone in a recovery room to the unearthly tones of electronic monitoring equipment and the random visitations of strangers.

Though by no means the only factor, the hospital trauma experienced by nine-month-old Teddy was an important, possibly critical, component in the shaping of Theodore Kazcinski, the alleged "Unabomber." It is likely, as well, that a terrifying hernia operation figured significantly in the formative process of Jeffrey Dahmer, the serial killer who tortured, raped, dismembered, and ate his victims.

The parents of both these men have spent many anguished hours trying to understand the actions of their sons. They had witnessed the disconnection, isolation, despair, and bizarre behaviour of their children following hospitalisation and surgery. The evidence pointed to the possibility that these permanent behavioural changes were attributable to traumatic reactions resulting from "routine" medical procedures. But, is this possible?

I have introduced these two extreme examples of violent behaviour to emphasize the fact that many events we deem ordinary or insignificant can be as traumatizing as the horrors of war. In 1946, Dr. David Levy presented scientific evidence that children in hospitals for routine reasons often experience the same "nightmarish" symptoms as "shell-shocked" soldiers. Fifty years later, our medical establishment is just beginning to embody this vital information. Based on this knowledge alone, the implementation of appropriate protocol could prevent the unnecessary traumatization of millions of people annually, as well as significantly lower health-care costs.

While most traumatized people are not outwardly violent, recent studies by Lewis and Pincus (and others) have shown that virtually all violent criminals have suffered extremes of childhood **abuse and trauma**. This evidence is compelling enough to significantly alter the way we view violent behaviour. However, because we currently lack the tools to create a new paradigm to address the roots of violence, we choose to sweep it under the musty,

overburdened rug of the criminal justice system—a costly and inadequate solution to this urgent problem.

A single brief exposure to an overwhelming event can throw a normally functioning individual (especially an infant or young child), into an abyss of emotional and physical suffering. Why this happens to one person while another remains relatively unscathed is not widely understood. Trauma is most commonly associated with events like war, extreme physical, emotional or sexual abuse, crippling accidents, or natural disasters. However, many seemingly harmless events can be equally traumatic. Automobile accidents resulting in “whiplash” frequently trigger bewildering and debilitating physical, emotional, and psychological symptoms, as do injuries resulting from falls, particularly in elderly people. Common invasive medical and dental procedures can be profoundly traumatic.

In order to prevent and reduce violent behaviour, we must acknowledge the crucial role that unresolved trauma plays in this arena. To quote Bessel van der Kolk from his definitive book **Traumatic Stress**, “Reenactment of victimization is a major cause of violence in society.” My focus here is on the violence intrinsic to traumatic stress. To address this issue, I will briefly define trauma, outline some of the current research on Post-Traumatic-Stress-Disorder (PTSD), present my approach to the subject (developed over the last thirty years), discuss traumatic reenactment in terms of this approach, and present possible models for both prevention and treatment of PTSD.

An event is potentially traumatizing if it is perceived (consciously or unconsciously) to be life-threatening. Freud envisioned trauma as “a breach in the protective barrier against (over)stimulation leading to feelings of overwhelming helplessness.” Due to the diversity of human responses to potential threat, it is difficult to identify or classify sources of trauma. What is devastating to one person is exhilarating to another.

Trauma as Pathology—the Predominant View

Since the dawn of humanity, the essence of trauma has been perceived through the eyes of Shamans from many indigenous cultures: its basic nature was captured powerfully in ancient Samaria and in the epics of Homer. Both trauma and its healing were then viewed as natural occurrences in which the whole community was involved, not isolated pathetic events. Despite this substantial foundation of understanding, as the “civilized” world systematically separated itself from the natural world, the

connection between trauma and nature was lost. Until twenty years ago, the "civilized" world's view of trauma had been reduced to "shell-shock."

In the 1970's, the Women's Movement widened the field considerably by indicating that the effects of domestic violence and rape are traumatic. Since that time, the study of trauma has merged with various disciplines in both the social and natural sciences. However, modern research and Psychiatry have not yet incorporated many of the essential elements of trauma into their studies, nor have they uncovered if, or by what means it can be healed.

Medical drug treatments have inspired a modicum of hope for the alleviation of symptoms that arise from this particular kind of suffering. However, I believe that the leading edge of theoretical and clinical work on PTSD is fundamentally limited by its predominantly mechanical view of human beings. For example, current research points to a causal link between trauma and brain pathology.

When autopsied after death, Vietnam veterans with long standing PTSD showed "shrinkage" in the hippocampus (a region of the brain involved in emotion and learning). This phenomenon was corroborated by laboratory research that detected similar brain damage in animals that had been subjected to protracted stress. These "broken brain" studies infer that the symptoms of PTSD (including memory lapses, anxiety, depression, and inability to manage emotion and violent behaviour), are due to an irreversible and incurable brain disease.

My first-hand experience with over a thousand traumatized people has convinced me that the aforementioned "brain damage" and other biochemical or molecular changes are **secondary effects**-that PTSD is not only preventable, but in many cases reversible. There is no way of knowing the condition of my clients brains prior to treatment, but the fact is that many people experience symptoms of PTSD within forty-eight hours of a traumatic event-much too soon for brain damage to occur. In addition, many of my clients, some of whom have been plagued for decades by persistent signs of PTSD, become symptom free in a relatively short period of time.

One helpful aspect of recent medical research on trauma is that it raises critical questions concerning the potential damage upon future generations of children ravaged by abuse, neglect, and violence. Unless we can learn to successfully treat the effects of trauma, we may be unintentionally

spawning hyperactive, learning-impaired, violence-prone, brain-damaged “citizens”, whose actions could rival Hollywood’s wildest nihilistic fantasies. Solving this threat to local and global social stability is one of our greatest challenges.

By no means limited to war and violence-torn areas of the globe, trauma is everywhere. Many middle class children and adults suffer from anxiety, depression, and psychosomatic disorders often related to the hidden effects of PTSD. In 1994, the conservative **Archives of General Psychiatry** reported that **half** of the **entire** American adult population meet the formal diagnostic criteria that denote **serious** psychiatric illness. A growing number of these people are susceptible to violent behaviour and substance abuse. Furthermore, even if people don’t exhibit obvious symptoms of PTSD, they may be functioning at greatly reduced potentials.

In summary, pathology-oriented trauma research may be (mis)leading people to believe that PTSD is incurable. At the same time, it has afforded ‘legitimacy’ to the very real suffering of people with PTSD. Rather than being told “It’s all in your (figurative) head”, a few of us may be comforted being told that “It’s all in your (literal) head.” In addition, the research raises important social questions: how do we as individuals, as a people, as a nation, and as a global community, plan to care about our traumatic experiences?

Trauma as Biology-Nature’s Lessons

When a situation is perceived to be life-threatening, both mind and body mobilize a vast amount of energy in preparation for the “fight or flight” response. This is the same energy that propels a one hundred pound woman to lift a ton of Detroit steel off of her sons legs. The task is supported by a substantial increase in blood to the muscles, and the release of “stress hormones” like cortisol and adrenaline. Researchers hypothesize that a **prolonged** excess of cortisol is what leads eventually to brain damage.

The area of medicine specializing in PTSD is a branch of “Biological Psychiatry.” An integral part of its standard treatment approach to the problem of excess of neurotransmitters and biochemicals like cortisol is **pharmacological** rather than biological. Currently, the search is on to find drugs that suppress the production of stress hormones. While such substances will afford beneficial relief of symptoms, unless the mobilized survival responses are addressed as well, the principal agent of PTSD will remain unchanged. Although medications are valuable tools, one

drawback with symptom inhibitors is they often suppress vital biological functions.

I believe it is possible to restore balance and prevent brain damage by learning how to **discharge** the residual energy mobilized in response to a life-threatening situation. This organismic discharge, when complete, informs the brain that it is time to reduce the levels of stress hormones—that the threat is no longer present. When this message to normalize is not given, the brain continues to release high levels of cortisol. If the situation persists, it could lead to brain damage. The central question is: what prevents people from returning to normal functioning after a perceived threat no longer exists?

It is through the study of the natural world that I began to understand the critical role of biology and instinct in both the formation and resolution of trauma. For a brief moment, I invite you to inhabit the Serengeti plain that dwells in your mind's eye. Let your senses rise as you visualize the crouching cheetah, its eyes focused, its muscles twitching in anticipation, as it prepares to attack the swift, darting, impala. Track your own responses as you watch the fleet cheetah overtake its prey in a seventy-mile-an-hour burst of speed. You may notice that the impala falls to the ground an instant before the cheetah sinks its claws into the haunches of its prey. It is almost as if the animal has surrendered itself to the predator.

The fallen Impala is not dead. Although it appears limp and motionless, its nervous system is still highly charged from the seventy-mile-an-hour chase. Though barely breathing or moving, the animal's heart and brain are racing. The same chemicals (e.g., cortisol and adrenaline) that helped fuel its attempted escape continue to flood its brain and body. There is a possibility that the impala will not be devoured immediately. The mother cheetah may drag its (apparently dead) prey behind a bush and seek out its cubs, who are hidden at a safe distance away.

Herein lies a window of opportunity. While the cheetah is gone, the temporarily "frozen" impala may awaken from its state of shock, then shake and tremble in order to discharge the vast amount of energy stored in its nervous system. After completing this normalization procedure, it will stand up on wobbly legs, take a few practice steps, then bound off in search of the herd as if nothing unusual had occurred.

The “death-feigning” or “immobility response” employed by the impala is as important a survival tool as are its better-known counterparts, “fight” and “flight .” Also called the “freezing response”, slow and relatively unprotected animals like the opossum use “immobility” as their first line of defence. Another of its vital functions is its analgesic nature. If the impala (or human) is killed while “frozen,” it will be spared the pain of its demise. Humans employ it extensively, though we tend to have trouble “normalizing” after being in this state. I believe that the ability to normalize after employing the “immobility response” is the primary factor in avoiding traumatization.

Like the cheetah and impala, we are living, breathing, pulsing, self-regulating, intelligent organisms, not merely complex chemistry sets. Current scientific focus on what is wrong (pathology) has diverted our attention from our innate human legacy to (with appropriate support and guidance) rebound and heal in the aftermath of overwhelming life events. A disturbance of the “normalization” process does not lead inevitably to incurable brain damage. We need to recognize our capacity as human beings to support and empower one another in the process of transforming trauma. Trauma is a fact of life, but it doesn’t have to be a life sentence.

Completion

For the impala, life-threatening situations are an everyday occurrence, hence it is reasonable to presume that the ability to resolve and complete these episodes is built into their biological systems. The human brain has three integral systems: reptilian (instinctual), mammalian (emotional), and the neo-cortex (rational thought). We share the first two segments of this trinity with reptiles and mammals, while the elaborate neo-cortex is singularly human. Since our instinctive function is virtually identical to that of the impala, it would follow that we, as well, possess the innate capacity to resolve threat.

In the **National Geographic** video “Polar Bear Alert” (available at video stores), a frightened bear is chased down by a pursuing airplane, shot with a tranquilliser dart, surrounded by wildlife biologists, and then tagged. As the massive animal comes out of its state of shock, it begins to tremble lightly; the trembling intensifies steadily, then peaks into a nearly-convulsive shaking-its limbs flail (seemingly) at random. The shaking subsides, and the animal takes three deep spontaneous breaths which spread throughout its body. The (biologist) narrator of the film comments that the behaviour of the

bear is necessary because it “blows off stress” accumulated during the capture.

When viewed in slow motion, it becomes apparent that the “random” leg gyrations are actually coordinated running movements. It is as though the animal **completes** its escape (by actively simulating running movements truncated at the moment it was tranquillised), discharges the “frozen energy,” then surrenders in a spontaneous, full-bodied breath.

In the late 1960’s, while studying animal predator-prey behaviours, I was intrigued by the similarity of the behaviour of many of my clients to that of the previously discussed impala and polar bear. I began to see that the “panic anxiety” experienced by a large percentage of traumatized people is **the sense of imminent danger** or impending doom associated with a thwarted urge to escape. **This**, I believe, is the essence of trauma; the urge to escape coupled with the **perception of not being able to**. Moving out of the “immobility response” can be a fiercely energetic experience. Unburdened by a rational brain, animals in the wild don’t give it a second thought-they simply do it.

When humans begin to move out of the “immobility response” they are often frightened by the intensity of the energy, and brace themselves against the power of their own sensations. This bracing prevents the complete discharge of energy necessary to restore normal functioning. Undischarged energy is stored in the nervous system, setting the stage for the formation of symptoms that become the precursors of PTSD.

I have since developed an approach that enables people to gently and gradually discharge these powerful instinctual energies. The name I have given to this process is “renegotiation.” If we arouse the “felt sense” of our own physiological resources, then **gently and** gradually uncouple the fear from the “immobility response”, we can consciously renegotiate our traumas with minimal risk of becoming re-traumatized.

Presently, many “trauma responders” and therapists are trained to encourage people to “relive” traumatic events with the emotional intensity of the original experience. The theory supporting this approach is that PTSD results from a fear of traumatic memories. It is thought that by reliving the experience, people will be able to face their fear and overcome it. However, if the fear is not uncoupled from the “immobility response,” the resultant emotional catharsis can be re-traumatizing

.Traumatic Re-enactment-the vortex of violence

It astonishes us far too little- Sigmund Freud

The drive to complete and heal trauma is as powerful and tenacious as the symptoms it creates. The urge to resolve trauma through re-enactment can be severe and compulsive. We are inextricably drawn into situations that replicate the original trauma in both obvious and unobvious ways. The prostitute or "stripper" with a history of childhood sexual abuse, the ex-combat soldier who joins a police SWAT team, the accident-prone person, and the person who repeatedly seeks abusive relationships are common examples of this phenomenon.

I define re-enactment as **an unsuccessful attempt to resolve the intense survival energy mobilized for defence against a perceived life-threatening experience.**

An accurate example of violent "acting out" was depicted in an episode of the TV show *Law and Order* entitled "Subterranean Homeboy Blues." In the opening scene, a beautiful young woman named Laura waits for a subway. She has a "far away" look in her eyes, and a mannequin-like rigidity in her body. Suddenly, a street person appears, flails his arms wildly in her face, then disappears. The woman's eyes follow him vigilantly, but her body remains still, almost frozen. She boards a crowded train, where two youths are acting menacingly. She pulls a gun out of her bag and shoots them both.

Six months prior to this incident, Laura, a professional dancer, had been raped and beaten by three men in a subway. Her injuries were so severe that after undergoing several back surgeries, she was forced to abandon her dancing career. In the wake of this tragedy, she purchased a revolver, intent on defending herself if the need should again arise-which, in her perception, it did.

Let's take a look at this scenario from a biological perspective. On the subway platform, we see an image of a woman who is severely traumatized. What are the clues? We notice a "far away" look, informing us that this person is somewhere else, not in her body. This "dissociative," state is a key symptom of trauma. Research has shown that dissociation is the single-most important predictor of chronic PTSD. Woody Allen's one-liner "I'm not afraid of dying, I just don't want to be there when it happens" is a whimsical way of describing its function. In itself, the far away look

could mean nothing more than simple “day-dreaming,” but when accompanied by a body that appears frozen (“immobility” is the biological underpinning of dissociation), it becomes more indicative of trauma. When the street person begins his eerie dance, rather than being annoyed, Laura senses imminent danger. She becomes suddenly alert, her protruding eyes following every jerky move the man makes. This quick jump from dissociation to (what is called) “hypervigilance” is further evidence of trauma.

With her nervous system now on “hair-trigger alert”, the woman enters a crowded subway car. The highly charged energy immobilized since she was brutalized has begun to move. The defensive response that she was unable to execute at the time of the rape explodes in a frenzy. Flight is not an option, there is nowhere to run. Her instincts urge her to fight, to discharge the intense survival energy held at bay.

To her psyche, no time has passed since the rape. It is as if she were frozen in time, as if it were happening right now. Instead of keeping her distance from the threatening youths, like a moth drawn to a flame, she sits down next to them, literally “sucked in” to the vortex of violence. One of the young men moves closer, and speaks to her. In a blur of intense “rage-counter-attack,” Laura pulls the trigger, again and again, obliterating the perceived threat. Then, it is over-the subway doors open, and Laura, in a robot-like trance, walks calmly away.

This scenario raises a compelling question: does violent re-enactment result in completion, thus resolving the trauma? The answer is almost certainly no. If that were the case, there would be no need for the repeated attempts to discharge and complete thwarted survival responses that characterize most people who “act out” violently. There would probably be far fewer serial killers and so-called vigilante avengers. Instead, after one violent act, most people’s nervous systems would normalize and they would go on with their lives.

Although “acting out” violently may provide temporary relief and a false feeling of victory and “pride”, without biological discharge, there is no completion. As a result, the cycle of shame and violence returns. The nervous system remains highly activated, which compels people to seek the only relief they know-more violence. The traumatic event is not resolved, and people continue to behave as if it is still happening-because, biologically speaking, it is-their nervous systems are still highly activated.

Psychiatrist James Gilligan, in his landmark book *Violence*, makes an eloquent statement: ... **“the attempt to achieve and maintain justice, or to undo or prevent injustice, is the one and only universal cause of violence.”** On an emotional and intellectual level, Dr. Gilligan’s insight is profound and accurate, but how does it translate into biological language? To the non-thinking world of the felt sense, I believe that the instinctual equivalent of justice is achieved by the complete discharge of energy mobilized to survive a life-threatening experience.

Despite the substantial emotional and social support that is increasingly available, women like Laura rarely get the help they need immediately following an incident. It is at this critical time that people can most easily be supported while they literally shake and tremble through the immobility, shame, and rage, enabling them to safely discharge the intense energy mobilized to defend themselves. If this does not happen, then the healing impact of individual or group therapy whose focus is on the “story” of what happened is severely diminished. ‘

There are a substantial number of women in prison who were convicted of murder and manslaughter under very similar circumstances as was the fictional Laura. The plight of these women, as well as that of countless other traumatized people, stands as an indictment against our failure to help each other resolve and heal from the devastating effects of trauma.

Why is re-enactment unable to completely discharge survival energy? The answer, simply stated, is “system overload.” If the instinctive urge to discharge intense survival energy is blocked (usually by fear), then the function of the two remaining brain systems is profoundly altered by this added burden of responsibility. The emotional brain is forced to translate instinctive energy into emotions (anger, rage, shame, love, or sadness). Then, the “rational” brain is called upon to create an idea.

(e.g., revenge, justice, nobody cares, everyone is out to get me, etc.) to support these emotions. The two inter-related systems do what they can, given the circumstances. However, the failure to instinctively discharge a very powerful biological energy puts both the emotional and intellectual portions of the brain in a position they are not adapted to handle.

The result of this dilemma is that the undischarged energy itself becomes a threat to the two overloaded systems. In reaction to this

internal threat, the emotional and rational brains focus on finding an external threat to “explain” the intense nervous system activation. Consequently, the emotional brain becomes fearful and confused, while the “rational” brain begins thinking irrationally, randomly identifying enemies to blame for having caused the internal distress. This hypervigilant search for threat sets the stage for violent re-enactment rather than renegotiation.

In areas where external threat is an every-day reality (e.g., war zones, inner-cities), the combination of undischarged internal survival responses, poverty, and life-threatening circumstances creates an explosive situation, one that is tragic and self-perpetuating. The formation of urban and rural gangs (cults, militias, etc.) has its roots in instinctual survival behaviour, but without the tools for renegotiation, the actions of these groups is limited to withdrawal from society and/or violent re-enactment. Due to the synergistic effect of intense feelings, warring tribes, ethnic and religious groups, and nations that are under constant threat are more susceptible to violent, irrational behaviour than are individuals.

It is humbling to own up to the possibility that a significant portion of human behaviour is attributable to hyper-aroused post-traumatic states. Most of humanity appears to be fascinated, perhaps even mesmerized by those of us who “act out” our search for justice. There are countless books and movies detailing the lives of “serial-killers and “revenge seekers”, many of them best-sellers or box-office bonanzas.

Underlying our powerful attraction to those who “act out” is the urge for completion and resolution. A person who has renegotiated a traumatic event is transformed by the experience, and feels no need for revenge-shame and blame dissolve in the powerful wake of renewal and self-acceptance.

The vast majority of traumatized people “act in.” They will turn the terror, rage and shame inwards, where it will systematically undermine their health and sense of well-being. Doctors estimate that they can find nothing medically wrong with at least eighty percent of patients who seek their help. A significant portion of these people are probably suffering from undiagnosed symptoms related to trauma and stress.

To commit violence on oneself is the method preferred by our culture for several reasons. Obviously, it is easier to maintain a social structure that appears to be in control of itself. However, I think there is another, equally compelling reason-by internalising the effects of overwhelming or injurious

events, we are denying that these experiences have a significant impact upon our ability to function. Where there is no conscious awareness, no need exists for personal or social responsibility.

It is important for us to understand that the strategy of internalising the effects of traumatic events is a form of violent re-enactment—one in which we become our own victims. Albeit less dramatic than “acting out”, “acting in” is no less violent. It is also no more effective in dealing with the highly charged energies mobilized to defend against what we perceive to be life-threatening circumstances. Furthermore, it is common for people who normally internalise their symptoms to have sudden bursts of “acting out” followed by feelings of deep remorse and self-degradation over what they have done.

For our Children

Eight-year-old Anna has enormous brown eyes. She could have been a model for one of David Keane’s popular paintings of almond-eyed children. The school nurse has just brought her in to see me. Pale, head hanging in defeat, barely breathing—she is like a fawn frozen by the bright lights of an oncoming car. Her frail face is expressionless, and her right arm hangs limply, as if it were on the verge of detaching itself from her shoulder.

Two days earlier, Anna went on a school outing to the beach. She and a dozen of her classmates were frolicking in the water when a sudden riptide swept them out to sea. Anna was rescued, but Mary (one of the mothers who volunteered for the outing) drowned after courageously saving several of the children. Mary had been a surrogate mom to many of the neighbourhood kids, including Anna, and the entire community was in shock as a result of her tragic death.

I had been invited to consult in this matter by a colleague who was a therapist for the School District. We had asked the school nurse to be on the lookout for children who displayed a sudden onset of symptoms (e.g., pain, head and tummy aches, and colds). Anna had already been to see the nurse three times that morning, reporting severe pain in her right arm and shoulder.

Previous traumas can re-surface in the aftermath of “overwhelm”, creating a complex situation that may involve “deep secrets”, untold shame, guilt feelings, rage, and pain. For this reason, we sought out and learned some

of Anna's history from several helpful elementary school teachers prior to seeing the child. The following information was revealed:

At age two, Anna was present when her father shot her mother in the shoulder and then took his own life. More recently, Anna had been infuriated when Mary's sixteen-year-old son Robert had bullied her twelve-year-old brother. There was a strong possibility that Anna harboured ill will towards Robert, and sought retribution. This raised the likelihood that Anna might feel profound guilt about Mary's death-perhaps even responsible for it. Anna was having trouble sleeping and had barely eaten in two days.

/ ask the nurse to gently cradle and support Anna's injured arm. This will help Anna contain the frozen "shock energy" locked in her arm, as well as heighten the child's inner awareness. With this containment and support, like the impala, Anna will be able to slowly, gradually, thaw, and access the feelings and responses that will help her come back to life.

"How does it feel to be inside of your arm, Anna?" I ask her softly.

"It hurts so much" she answers faintly. Her eyes are downcast, and I say,

"It hurts bad, huh?"

"Yeah."

"Where does it hurt? Can you show me with your finger?" She points to a place on her upper arm and says, "Everywhere, too....I couldn't swim....I thought I was going to drown."

There's a little shudder in her right shoulder followed by a slight sigh of breath. her drawn face relaxes for a moment, and the pace of her racing heart begins to slow .

"That's good, sweetheart-does that feel a little better?' She nods slightly, then takes another breath. After this slight relaxation, she immediately stiffens, pulling her arm protectively towards her body. I seize the moment.

"Where did your mommy get hurt?' She points to the same place on her arm, and begins to tremble. Nothing more is said. The trembling intensifies, then moves down her arm and into her neck. "Yes, Anna, just let that shaking happen-just like a bowl of Jell-O-would it be red, or green, or even bright yellow? Can you let it shake? Can you feel it tremble?"

"It's yellow," she says, "like the sun in the sky." She takes an almost full breath, then looks at me for the first time. I notice that her face has taken on a rosy hue; I smile and nod. Her eyes grasp mine for a moment, then turn away.

"How does your arm feel now?"

"The pain is moving down to my fingers." Her fingers are trembling gently. As I speak to her quietly, softly, rhythmically, her heart rate, in a dramatic shift, becomes normal.

"You know, Anna sweetheart...I don't think there is anybody in this whole town that doesn't feel like that in some way it was their fault that Mary died." She glances at me briefly, and I continue-"Now, of course that's not true...but that's how everybody feels...and that's because they all love her so much." She turns now and looks at me. There is a sense of self-recognition in her demeanour. With her eyes now glued on me, I continue..."Sometimes, the more we love someone, the more we think it was our fault." Two tears spill slowly from the outside corners of each eye before she slowly turns her head away from me.

"And sometimes if we're really angry at someone when something bad happens to them, then we also think that it happened because we wanted it to happen." Anna looks me straight in the eye, and I say, "And you know, when a bad thing happens to someone we love or hate, it doesn't happen because of our feelings. Sometimes bad things just happen...and feelings, no matter how big they are, are only feelings...and you know, Anna, 'cause you love Mary it's supposed to hurt, but it won't hurt forever." Anna's gaze is penetrating and grateful. I feel myself welling with tears. I ask her if she wants to go back to her class now. She nods, looks once more at the three of us, then walks out the door, her arms swinging freely.

Traumatized children can become fearful, hyperactive, clinging, withdrawn, "bed-wetters", or impulsively aggressive, violent bullies, in the aftermath of overwhelming events. They often have nightmares and head and tummy aches. There are a few simple guidelines we can use to help children (and adults) move through the intense fear and isolation often associated with injuries, abuse, witnessing violence, loss of a loved one, and medical procedures. If this information is incorporated into our existing medical and paramedical models, as well by as crisis and counselling centres, "hotlines," etc., it could prevent much unnecessary suffering and reduce health care costs dramatically.

Trauma prevention

From Reader's Digest , here is a father's description of the effects of a "routine" medical procedure on his son that could have been easily prevented:

The doctor tells me that everything is okay. The knee is fine, but everything is not okay for the boy waking up in a drug induced nightmare, thrashing around on his hospital bed—a sweet boy who never hurt anybody, staring out from his anaesthetic haze with the eyes of a wild animal, striking the nurse, screaming 'Am I alive?' and forcing me to grab his arms....staring right into my eyes and not knowing who I am.

Trauma leaves people feeling alone and isolated. We must adapt our social structures so that they reflect a "compassionate presence"—one that can help people rejoin the human herd. For example, children (and adults) hospitalised for surgical procedures need advocates. Many up-to-date hospitals already employ people who offer informational and emotional support in a limited way. However, I am proposing that surgical patients be assigned advocates that stay with them at critical times.

A vast majority of traumatic reactions can be prevented by not allowing anyone, especially children, to be restrained, put through invasive procedures, or anaesthetised while unduly frightened. If a person is frightened, time needs to be taken afterwards to help resolve the fear. The advocates would also be present in the recovery room to offer contact, support, and reassurance as the patient awakens from anaesthesia.

Following a potentially traumatizing event, emergency personnel can be trained to help guide people through relatively simple "de-activation" procedures. In addition, by adhering to specific surgery-room protocol, surgical staff (doctors, nurses, etc.) can minimize or prevent the onset of PTSD in many of their patients.

Trauma is about the loss of connection—to the self, to others, to nature, to everything. If we work together, our success in healing and restoring these broken connections will increase dramatically. The implementation of the above-mentioned ideas to help both prevent and renegotiate trauma is a small but important step toward a much larger goal—to experience the joy of being fully human, and to live our lives in relative stability, safety, and

peace. Toward this end, the creation of models for trauma resolution adapted for use in violence and war-torn areas throughout the globe is theoretically feasible.

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