Working with Trauma with EFT

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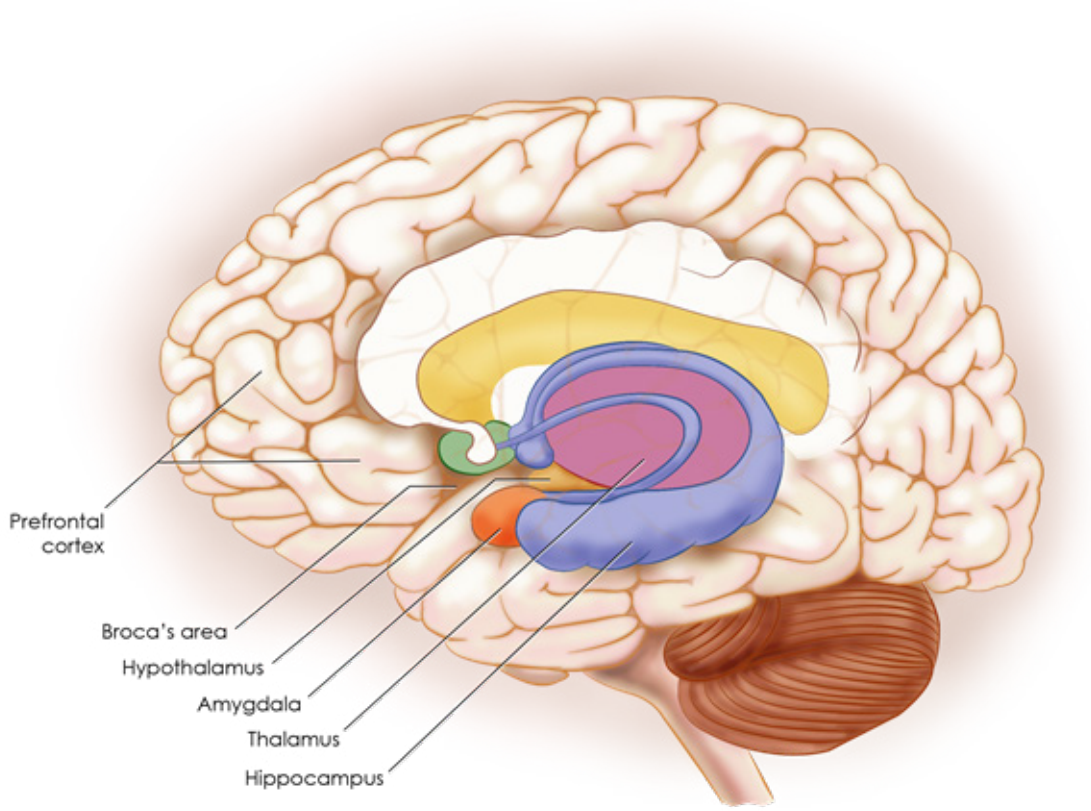


THE IMPACTS OF TRAUMA

It is an exciting time to be doing trauma work. And a challenging one. New insights and richer resources are emerging almost every week. Theoretical progress is throwing up new therapeutic possibilities and resources, as well as challenges, all the time.

Trauma has neurological, physiological, psychological, psychosocial and developmental consequences. In this opening section we will look at how state-of-the art understanding of them helps us to know how best to help people suffering from post-traumatic stress.

Later, we will begin to explore the differences between the trauma of childhood abuse and single or multiple adult traumas that threaten physical or psychological survival or both. We will look at why and how we need to work differently with them. And we will begin to explore why people who suffered the former are hit harder by the later and have compromised resources for recovery.

Psychoeducation is key in all trauma work. Traumatized clients need to know what is happening to them and how and why. And therapists dealing with trauma need to understand what is happening to their clients and how and why to give them the best available help relevant to each client.

For clients, facilitating this understanding removes one of the many layers of their suffering. They need to really understand that they are not going mad, they are not weak, that their reaction is not an abnormal one or shameful but a normal response to an abnormal experience. This is essential reassurance for sufferers and for those close to them.

Knowing that what is happening has neurological and physiological levels and is a biological inevitability can remove another layer. We react to trauma as we have been programmed by evolution to react. It is not a matter of decisions or choices. It is how we survive.

Such understanding, as long as it is pitched at the level appropriate to each individual client, is also a key part of building the deep trust relationships between you and your traumatized client and between the client and themselves - essential pre-requisites for trauma therapy to happen at all, let alone to have a positive outcome.

WHAT IS TRAUMA?

These chapters will consider trauma to include everything across the spectrum from the small “t” or “everyday trauma” of childhood from which we discover ourselves and the world to the major trauma of a situation in which we are helpless and in which we perceive our lives or the lives of others to be threatened.

The word “trauma” comes from the Greek for wounding. I find that a helpful way to think about it is to think about what it is that is wounded. I see it as damage to our inbuilt self-healing mechanisms. Just as our bodies marshal all their healing resources to repair when we cut ourselves, I think that we have a built-in mechanism for emotional healing as well. Trauma does not just damage our psyche, but it also wounds the self-healing system that strives to make us and our world okay again.

A trauma is something that overwhelms our ability to process, learn if there is a lesson to be learned, let go and move on.

In fact, trauma often does “teach” us lessons, but they are often not adaptive ones. It is from traumatic experiences or situations that we make maladaptive

assessments and decisions such as: “I am not good enough.” Or “My parents would not have divorced if I had been a better child”. Or “If they treat me like that, I must be evil.” Or “I will never trust anyone to get close to me again.” Or “the world is not safe.” Or “danger is everywhere. I must always be alert.”

They also install habitual and maladaptive behaviour patterns that kick in automatically whenever something inside or outside us reminds us of the trauma.

IMPORTANCE OF TRAUMA IN OUR WORK

Even if you decide not to make major trauma a special interest in your work working with trauma at every level is one of our most crucial tasks of and it is one to which EFT is particularly well suited.

And, as you have been using EFT with clients, you will already know the extent to which it takes us where we need to go and how often that turns out to be some level of trauma that underlies any emotion we are targeting with tapping.

Of course that covers the broad spectrum from the “everyday” or “small t” traumas of our early years from which we make decisions and internalize beliefs about who we are and how we are and how safe the world is all the way up the scale to those terrifying experiences or situations where our lives and those of others seems to be threatened.

We know that even low-level early trauma is a predictor of who will be most likely to suffer post-traumatic stress as a result of later traumatic experiences.

As well, over the last couple of decades we have increasingly realized the extent to which many diagnoses have been just plain wrong. What was being labelled attachment disorder, for example, or depression, or borderline personality disorder or an anxiety disorder has subsequently been understood in many cases to be post-traumatic stress.

We have also come to understand that when a diagnosis is accurate it has often been caused by early trauma.

Much of this new insight has been a clinician-led. A lot of this book will look at how neurology research has given us new information to incorporate into our work. But I would first like to look at how therapy has helped shape theory.

Working with EFT and with EMDR and peeling back the onion layers as both techniques do, we so often find it is where the work spontaneously and

unambiguously leads us.

EMDR is Eye Movement Desensitization and Reprocessing. It dates back to 1989 when Francine Shapiro published as her PhD thesis a study of using bilateral stimulation with eye movements with Vietnam veterans who still had severe Post Traumatic Stress Disorder a couple of decades after the end of that war.

There was so much improvement in the treatment group that she subsequently turned the control group into a second treatment group so that they, too, could benefit from her insight.

In many ways EMDR and EFT are twins, and not just because of the age similarity. I think there is much in EMDR and its insights and its research that we can incorporate into our EFT trauma work and I borrow or steal from it shamelessly.

When EMDR first hit the streets, it was way ahead of any trauma treatment that went before. However, while Gary Craig freely gave EFT to the world, Francine Shapiro restricted EMDR training to tightly defined professional groups such as clinical psychologists and psychiatrists because, she said, she believed it was too powerful to be safe in the hands of people without considerable additional therapy skills. These contrasting attitudes of are a major way in which the twins were non-identical and set them on different paths.

Gary Craig did not attempt to limit the use of EFT beyond saying: “Don’t go where you do not belong.” I agree. I believe it is our responsibility, if we are using the power of EFT to deal with major disturbances such as serious trauma, to build for ourselves the relevant additional skills.

Because the first people using EMDR tended to work in places where they had a regular population of patients/clients to be subjects, it had a lot of early outcome studies which brought swift acceptance.

I think it is useful if you want to specialize in trauma to be aware what EMDR is so you can weave elements of it and insights from it into your EFT.

In the interests of transparency, I will tell you that I trained in EMDR before most people had ever heard of it and before I had heard of EFT. So, I am an early adopter of the seemingly odd. For a time, I would have said I gave it up in favour of EFT. I preferred and still prefer EFT.

But I didn’t really realize for a long time the extent to which insights from it became interwoven with EFT both in my own client work and in my trainings.

I would have said EFT had completely replaced EMDR for me. I have come to understand how much it informed my EFT and it will be there inextricably interwoven in what I say about EFT and trauma.

This is becoming a two-way street. I am intrigued to notice how many psychiatrists and psychologists who use EMDR have started adding EFT to their work.

Two valuable EMDR insights equally relevant to how we think about EFT and trauma were these:

EMDR takes people where they need to go. So does EFT. And it seems so often to be the same place – the traumatic experiences in which beliefs were formed or decisions made which become part of that unconscious map of the world that runs our lives. To me that says this is not a technique artifact but a truth about how humans are.

EMDR demonstrated spontaneously that being a whole, healed person requires not just for the post traumatic symptoms and the emotional residue to be neutralized but for people to have come to terms with themselves and their experience in some way that is meaningful to them.

EMDR's original name did not include the Reprocessing. Francine Shapiro added it because her experience was that people did not seem to feel finished when they had just desensitized the emotions. They would push her to go on to changing to a new understanding of the event or their reaction to it.

That is just what we find in EFT, too. People reframe spontaneously or more readily accept appropriate reframes offered by sensitive and skilled therapists working within a client's world view rather than their own. It is as if, once the emotional residue is removed, people can see things in a different light.

Their innate self-healing mechanism wants to complete the healing.

This convergence of the two techniques confirms how key those experiences are to where we find ourselves years down the line. They are not products of the EFT and EMDR techniques. They are what the two approaches reveal about how human beings operate neurologically and physiologically and psychologically in their lives and in society.

And this is why we will return to the topic of the therapeutic value of helping clients finding meaning not just in specific events but in their lives post-trauma.

This awareness of our natural inclination to find meaning should also alert us to listen to one of the big potential blocks to trauma recovery. Is past trauma providing meaning for a client? Is membership of the group who shared the

trauma, giving meaning to a life that would otherwise be perceived as lacking it at this time?

Think, for example, of ex-service people suffering PTSD and feeling the only place they belong and are understood in civilian life is in a group of fellow sufferers.

If so, besides other therapeutic approaches and negotiations you might be looking down the line at psychological reversal with set-ups like: “Even though I do not know who I would be/how I would be/where I could belong/…” Or: “Even though I would be being disloyal to those others if I …”

The other insight that both EMDR and EFT confirm for me is that memories are stored in metaphorical filing cabinets that do not make logical left-brained sense. If we are exploring cognitively for links, we might expect a drawer full of mother memories, perhaps, and another of father memories and so on. What we find is seemingly quite related events which probably have more subtle connections. So one drawer might have a series of seemingly random events which might have the same underlying belief attached to them. It might be an “I am not good enough” drawer. Or an “I am not lovable” drawer. Or an “I am not safe” drawer. We may never get what the connection is. We do not have to.

But it does underscore the importance, when we are working with a negative memory and a client spins off to something seemingly irrelevant event, of recognizing such apparent diversions as probably pure therapy gold.

EFT shows us where we need to go. We need to trust the process, rather than probing for links that make sense to our rational brains. As Bessel van der Kolk, one of the world’s leading trauma experts says: “The body keeps the score”.

The final message that I take from EMDR into EFT is the importance of bilateral stimulation and what that really means for us using EFT.

When EMDR started to get what seemed at the time to be startling results for therapists, neurologists also began to study what was happening before and after trauma work especially to see what it could teach us about brain function.

The consensus – beyond the usual more research is needed – was that the core element was bilateral stimulation.

When I first did EFT the nine gamut procedure was part of the standard EFT protocol. Many of us found doing it and selling it to clients was something of a barrier to wholehearted acceptance of EFT.

It was bad enough that clients expected a “normal” therapist and found someone who wanted them to sit and tap on their faces. Rolling their eyes and humming out loud seemed to be going too far. It seemed too far to many therapists, too.

Later, I learned to tell clients it was (as it is) a brain balancing exercise which shifts the processing from side to side in the brain and I felt better about it. Which meant so did they.

And around the same time Gary Craig decided that the standard was now what we used to call the short form which had the head point added and the nine gamut taken away.

I noticed over the years, however, that some of the most experienced practitioners whom I really admired made a point of including the full long form in sessions at least once or twice.

So I was interested to read this written by neurologist Dr Robert Scaer talking about EFT in 8 Keys to Brain-Body Balance: “The methods it (EFT) uses reflect many of the criteria that I feel are necessary for fear extinction.

“… The patient then rotates the eyes to the right and to the left, hums a few verses of a song, counts one to five, then repeats the humming.

“Although these admittedly peculiar actions would seem to defy logical function, they do indeed contain elements that might inhibit the amygdala – empowerment, brain hemispheric crossing (alternating rotation of the eyes; humming to activate the right side and counting to activate the left) and perhaps even ritual.”

Dr Scaer elsewhere identifies ritual as one of the things he thinks useful in clearing trauma. Ditto a self-empowerment statement. We could see the “I accept myself of the set-up” which we repeat while tapping on the side of the hand, as remarkably self-empowering. Therapists from Carl Rogers onwards have argued from their theory and their experience for the importance of self-acceptance as a prerequisite for change success. Later we will look at other ways to empower clients by giving them control of the work we do together.

Gary Craig says we no longer need to use the self-acceptance set-up but many of us prefer to continue to do so, both for the structure it gives to our work and even more for the benefit to clients of accepting themselves, or at least attempting to.

P0ST TRAUMATIC STRESS OR POST TRAUMATIC

STRESS DISORDER?

Let's get the rest of the definitions out of the way before we really dive into working with trauma. What is the difference between post-traumatic stress and post-traumatic stress disorder?

To be post-traumatic stress disorder, a person needs to fit certain criteria laid down by the DSM-5, the fifth and current edition of the Diagnostic and Statistical Manual of Mental Disorders published in 2013.

If you do not consider yourself qualified to diagnose this may seem irrelevant. And you may resist the idea of diagnosis because it puts people into boxes, and no one is a perfect fit. We try to get into the world of our clients rather than fitting them into ours.

But I would recommend asking clients if they have had a diagnosis and, if they have, how they feel about it, rather than letting our own feelings about diagnoses colour our perception. Some clients find a diagnosis extremely helpful because it validates and normalizes what they have been experiencing. As validating and normalizing are as part of what we are aiming to do, we can use it to further our mission if their perception is positive. And if their reaction to it is negative, the diagnosis itself might be traumatic memory that we need to deal with down the line.

The current DSM-5 was launched to a storm of protest from bodies in the US and the UK. Even before it was released, the American Journal of Psychiatry published the results of validity tests of several new diagnoses and said that DSM largely lacks reliability, the ability to produce consistent results.

The British Psychological Society complained that the sources of psychological suffering in the DSM-5 were "as located within individuals" and ignored "undeniable social causation."

In the US the National Institute of Mental Health, the source of funding for most psychiatric research in American, announced just before it was published that it would no longer support what it called DSM's "symptom-based diagnosis."

Whatever reservations you have about DSM diagnosis, having at least a nodding acquaintance with its classifications is useful for communicating with other professionals like psychiatrists and psychologists in the field and with clients who have a diagnosis. Other professionals will be more likely to accept our expertise if we speak and understand their language. It will help us understand what they are saying.

More importantly clients may look to us to explain their diagnosis.

WHAT IS POST TRAUMATIC STRESS DISORDER (PTSD)?

PTSD's classification has been changed in DSM-5 from a type of anxiety disorder to a new category "Trauma and Stress-related Disorders". This could be one of its plus points. It could potentially help de-stigmatize PTSD since it is now connected to an external event.

Qualifying traumas in the new PTSD classification would be experiencing exposure to actual or threatened death, serious injury or sexual violence experienced directly, or witnessed, or hearing of the accidental or violent death or a close friend or relative. Repeated exposure, such as first responders' experience, would now also count.

To qualify, people must have dysfunction in their lives and/or clinical levels of distress for longer than one month. If it is less than a month it might still qualify as acute distress disorder.

There are four relevant sets of symptom clusters:

Intrusion or Re-experiencing intrusive thoughts or memories, nightmares that are related to the traumatic event, flashbacks, feeling as if the event is happening again, and psychological and physical reactivity to reminders such as an anniversary of the traumatic event.

Avoidant symptoms describes ways someone might try to avoid any memory of the event, and must include one of the following:

Avoiding thoughts or feelings connected with it

Avoiding people or situations connected it.

Negative alterations in mood or cognitions which include decline in mood or thought patterns like memory problems related to the event, negative thoughts or beliefs about themselves or the world, distorted sense of blame related to the event and about themselves or others, being stuck in severe emotions related to the trauma (e.g. horror, shame, sadness), severely reduced interest in pre-trauma activities, feeling detached, isolated or disconnected from other people

Increased arousal symptoms which describe how their brains stay wary and watching for further threats. Symptoms of this include:

Difficulty concentrating

Irritability, increased temper or anger

Difficulty falling or staying asleep

Hypervigilance

Being easily startled

There is also a dissociation sub-type that covers derealization, the sense that what is going on around a person is not real and depersonalization, which is the sense of not being real themselves.

So that gives you a more detailed understanding of what it means when someone has been diagnosed with Post-Traumatic Stress Disorder. It is also a pretty good description of what you might expect to see in any seriously traumatized patient whether they qualify for a DSM diagnosis of PTSD or not.

It is worth bearing in mind, too, that when research describes people as no longer suffering PTSD they may still be suffering post-traumatic stress but just not meeting the DSM criteria.

JUST USE PTS

I tend to use Post Traumatic Stress to cover both those who meet the classification for Post Traumatic Stress Disorder and those who do not. That is the style I will follow throughout this book.

UNDERSTANDING MIND BODY

The 20th century began a change in our perception of the relationship between mind and body which is continuing into the 21st. Increasingly they are seen not just as related and mutually influential but as a single system. The dualism that began with Descartes in the 17th Century has been eroded by advances in our knowledge and changes in our thinking about ourselves.

Every part of the body is represented in the brain and sends signals to the brain. The brain not only decides the relevance of those messages for brain and body but sends signals to the body about what information it wants collected and transmitted.

Now here is the startling fact about that. About 80 per cent of the traffic is from brain to body and the rest in the other direction. Traumatized people

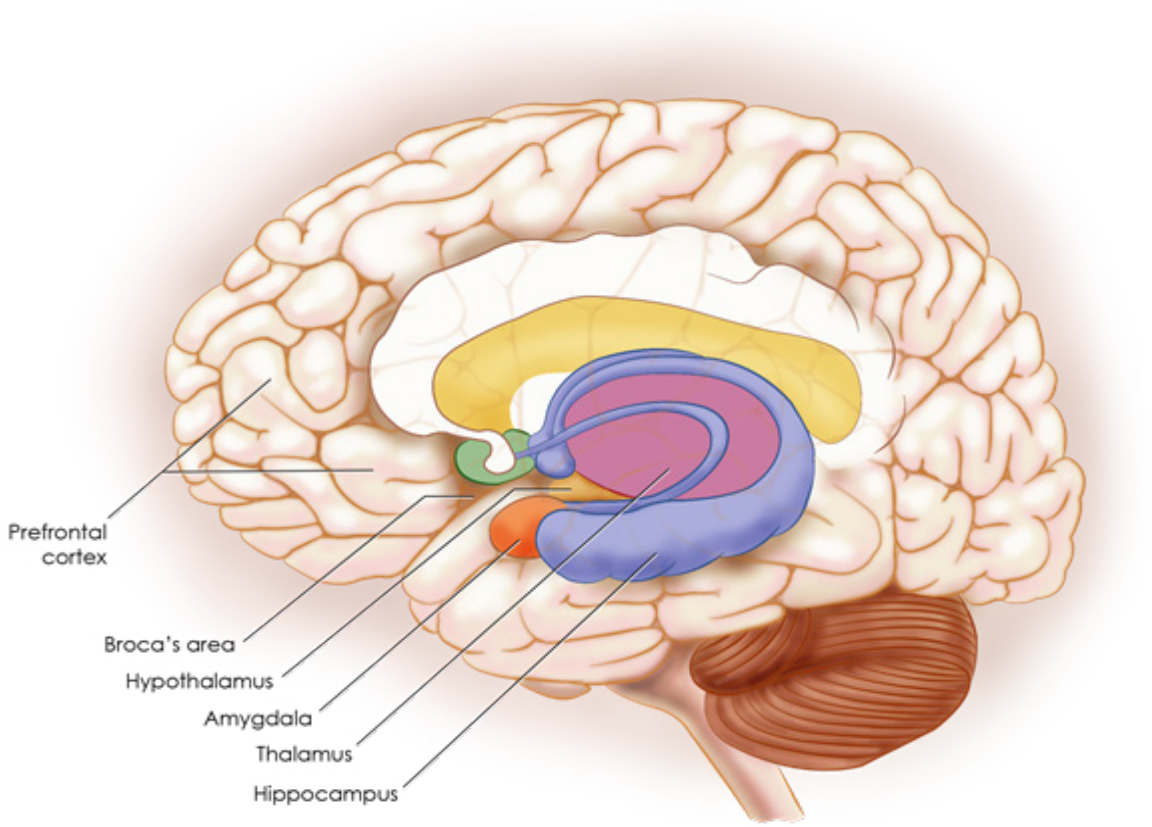
constantly and unconsciously seek confirmation that the world is unsafe.

In other words, we see the world not as it is but as we are. That is a key insight in working with trauma.

But what has refined our understanding and taken it to a new level is Stephen Porges polyvagal theory which puts the spotlight on the polyvagal nerve as a mechanism for this bidirectional transmission and much more. To oversimply its complexity and its enormous ramifications, it means that by calming our body we can calm our minds.

And what calms the body better than EFT?

TRAUMA AND THE BRAIN



The **hippocampus** from the Latin for sea horse because it looks like one shrinks with traumatic stress

gets bigger with use – larger in London cabbies who had to

learn the whole map of London

home to short-term memory

has “senior moments”

The **thalamus**	breaks down with trauma and does not integrate
	sensations into autobiographic memory
	"the cook" in Bessel van der Kolk's metaphor*
	collects information from the outside into "this is what is happening to me."
	fast-tracks data to the reactive amygdala and slow-tracks to the rational prefrontal cortex
The **amygdala**	is the smoke alarm* or Wi-Fi or security camera
	doesn't think, it reacts
	you cannot talk to it
	with trauma gets bigger
	with trauma gets easier to trigger
	triggers fight/flight/freeze
Hypothalamus	secretes stress hormones to enable fight/light when the amygdala says to
Broca's area	major speech centre
	shuts down in trauma and tress
Prefrontal cortex	Van der Kolk's watchtower*
	With trauma the balance between the thoughtful
	watchtower and the reactive smoke alarm gets out of whack. So control of emotions and urges is less available.

* Bessel van der Kolk's The Body Keeps the Score.

When someone is suffering post-traumatic stress, the effects are:

1) The threat perception system is enhanced. It works overtime. People see danger in primitive perceptual part of the brain. They become fear-driven. Fear has a survival value in helping preserve us from danger. But in trauma everything becomes danger.

2) The filter higher up in the brain that helps us ascertain what is relevant now and what we can just dismiss gets messed up. It is hard to focus on now. It is hard to tell then from now.

3) The self-sensing system in the mid brain – our experience of ourselves – becomes blunted. This is a defensive mechanism because if we experience terror in body it feels bad. To cope, trauma sufferers may also use drugs to dampen the sensations. The trouble is that, at the same time, they dampen their capacity for pleasure and connection. The sense of aliveness is damped down. That is why people who have unresolved trauma may paradoxically feel most alive when in danger situations.

They may both hate what they have gone through but also be attracted to re-experiencing it. They may feel numb. They may feel most alive in situations like the one in which they were beaten up or molested or in a dangerous war zone. They may find what makes them feel bad also makes them feel alive.

In trauma, our bodies produce endorphins to help numb the pain. This can set up a conditioned response between things that remind us of the trauma, for example horrific images, and the release of endorphins in our systems. These can give us a high that lasts some time.

So pleasure and pain may become mixed up in trauma victims. They may be unable to enjoy the small pleasures of everyday life. They may feel good only when they feel bad.

A conditioned response – an automatic response to a stimulus that has been paired with it as was the case with food and the sound of a bell in Pavlov's dogs - is set up in trauma between anything internal or external that reminds the traumatized person of the traumatic event.

If you remember, once the dogs had experienced repetition of the bell without the food, the conditioned response was extinguished. That is something we are trying to do with our trauma work – to extinguish the conditioned response of the amygdala to perceived danger.

TRAUMA AND THE BRAIN/BODY

The old story we learned about trauma

There is a balance between:

Sympathetic nervous system

Parasympathetic nervous system

Sympathetic has fight/flight/freeze. Under perceived threat, they get out of balance and sympathetic runs the show. Our bodies become ready to fight or flee. When the threat passes or is escaped, the parasympathetic restores the balance.

The new story

Thanks to Stephen Porges' polyvagal theory we now know:

The parasympathetic has two branches:

The ventral vagal, which is the social engagement system and the dorsal vagal, which is shutdown.

So the overall story becomes a hierarchy of responses as follows:

Parasympathetic Ventral vagal - social engagement system

Sympathetic – fight flight

Parasympathetic dorsal vagal slowdown, flop.

What this translates to is that, under threat or perceived threat, we:

Try to talk or smile our way out of the danger by using our social engagement system.

Fight or flee.

Shut down and possibly even faint.

The polyvagal nerve is a transmission system of two halves. Darwin actually said in 1872 that there was a nerve that connects brain with body and whenever people have a strong emotion they experience heart-wrenching and gut-wrenching sensations as part of the trauma. He also pointed out that this was a two way street. Signals from body to brain and brain to body.

But it has taken decades of dedicated work by Stephen Porges, Director of the Brain-Body Centre at the University of Illinois at Chicago to refine our understanding of the role and function of the polyvagus in ways that make sense of much of our experience and gives us a new map for understanding and working with trauma.

What is still described as polyvagal theory but is increasingly accepted as the orthodox paradigm in the field, is that the vagus (or tenth cranial) nerve has two distinct branches in mammals which evolved at different times and have different functions. The more primitive elicits immobilization behaviours such as feigned death in animals and shut down, even fainting in humans. The more recent branch is linked to social communication behaviour and self-soothing.

They operate in a hierarchy. The more primitive shutdown response to danger comes into play only when all else has failed.

The dorsal (or back) branch of the vagus is unmyelinated and most vertebrates have it. Think reptile. Primitive animals have no other stress response but to shut down and conserve their resources.

As mammals evolved more neural complexity they developed a myelinated ventral (front) branch of the vagus, also known as the "smart vagus" because it is associated with the regulation of sympathetic "fight or flight" behaviours to enable and use social communication and self-soothing and calming.

So this smart branch may be able to inhibit or disinhibit defensive limbic circuits, depending on the situation. Of this more later.

However, when we are able to calm the body in recollection of trauma, then we are able to calm the brain by a different group of structures in the mid-brain. And of all the functions of EFT that are not understood or have disputed understanding, one thing we do know is that tapping calms the body.

FIGHT/FLIGHT REWRITE EXPANDED

We used to think we had it nailed. It went like this:

Sympathetic nervous system. Under threat, or perceived threat, it triggers the fight/flight/freeze response. Our bodies ready themselves for one of the options. The bronchial tubes are dilated so we can take on board more oxygen. The blood flow, now with extra oxygen, is diverted to the muscles of the arms and legs to facilitate physical action. The pupils or our eyes are enlarged to improve eyesight.

At the same time there is a shutdown of functions not necessary for fighting or fleeing. Digestion and immune response are put on hold. And there is shut down in the rational pre-frontal area of the brain. We do not need to do sophisticated calculus calculations while we are fighting for our lives.

Once the threat is over, the Parasympathetic nervous system restores the balance.

The new understanding means this:

Under threat, our first response is that of the ventral vagal which attempts to defuse the situation with **social skills**. We may try to talk our way out of threat with words, smiles and so on. Social engagement is our first line of defence.

This system is the baby of the trio. It is probably only about 40,000 years old and recruits middle ear, face and throat in our defence, although its functions go beyond defending us.

The second line is **fight/flight** as described above. It is probably about 275,000 years old. To put that in perspective, Homo sapiens has had been around for about 200,000 years. It is still understood to be the system that operates and explains most of our "everyday" anxiety responses.

So how does this work in practice? Say, for example, you think someone is trying to lull you into relaxing your guard because they are getting ready to snatch your phone. Instinctively, you might first try to smile at them and to engage them as a human being, to win them over so they leave you alone.

When that is failing, or when you unconsciously consider it for a split second and dismiss that as a possibility, you might switch into fight/flight with adrenaline giving you blood flow to your legs to run or your fists to fight or both.

And if that does not seem unconsciously to be an option, you may give up. You may possibly even faint.

The ventral vagal is myelinated – covered with a fatty sheath which means communication along it is much faster than in the more primitive unmyelinated dorsal vagal.

Some have credited myelinogenesis - the production of the myelin sheath – and the faster internal transmission abilities that came with it - as the time in our evolutionary history when we our ancestors took a big leap forward to being what we would classify as human.

In the individual myelinogenesis, starts about the 14th week into the life of a foetus. However, there is still little of it in the brain of a new-born infant. It develops quickly in the early years. The critical importance of this and the conditions that facilitate it become apparent when we look at attachment.

The third stress response option is controlled by the dorsal (or back) vagus which links gut and brain. It is here the response to the greatest perceived danger is shutdown. This is the ancient mechanism of reptiles with

no defence beyond conserving resources. It began in fish before it moved on to reptiles and is still around in us. This part of our range of options is our last-ditch response and is completely involuntary.

It is important for people suffering from trauma to understand that fight/flight and flop or shutdown are in-built automatic responses that have evolved over millennia. They happen fast and with inevitability. There is no negotiating with them.

Under enormous stress, and with the perception of helplessness which is part of the definition of trauma, we cannot negotiate a deal with our automatic responses not to kick in. The rational, thinking parts at the front of the brain will have stopped working at all.

Often people who were unable to act to save themselves from injury or to rescue someone else, or to stop an attacker in his tracks have a lifetime of shame/guilt/ self-blame for what they were unable to do. Or even for surviving when others they could not save did not. They need to know that no one can decide how they will respond in such situations. They truly had no choice.

This may mean, of course, that people who have been unable to put up a fight may have no defence wounds to prove they were attacked if they take a case to court. Rape victims who did not fight back, either because they calculated that not doing so was their best chance for survival, or because their dorsal vagal response stopped them from having a choice, may have a hard time proving they did not consent to sex with a rapist.

Fight/flight/freeze?

On average ten times as many neurobundles go to sense organs as from them. What that means is that we tell our senses what to notice ten times as much as our senses tell us what they detect. This is key. We are built to keep seeking confirmation of what we already expect.

The hippocampus just below the amygdala does initial memory processing and retention.

Traumatic stress shrinks the hippocampus. Not only its function is influenced. The actual structure is changed. It is also possible, though as yet unproven, that people who are more prone to be traumatized by negative events start with a smaller hippocampus. Either way it may be that this is part of the complicated series of factors that make people who had early trauma more prone to traumatization as adults.

The hippocampus is the home of short-term memory. Hopefully it knows where you parked your car. This sort of working or short-term memory is stored on both sides so if you have physical brain damage it will need both sides to be destroyed to lose your short-term memory ability.

Short term memory also declines with age. We recognize this by using the expression "a senior moment" for experiences like going into a room for something – and forgetting when we get there what the something was.

This is one of the most plastic areas of the brain. Not only does it shrink with trauma but it can grow with the right stimulation as well. Structural MRIs of the brains of London licenced taxi drivers, who had to have a huge amount of navigational information stored in their heads to earn a licence, showed their posterior hippocampi were significantly larger than those of controls. The longer they had been taxi drivers the more the posterior increased and the anterior decreased.

And, intriguingly, small mammals and birds who need to have good internal maps, for example of where they have stored food, have the same neurological response to their environment's demands.

The **Amygdala** –attached to the hippocampus – is the gateway for information processing and for triggering survival responses throughout the brain and body. Its structure and function are also damaged by trauma. It gets bigger and becomes more prone to trigger a survival response constantly.

Blaise Pascal said in the 16h Century that "We perceive the world not as it is but as we are." He was not wrong.

The amygdala doesn't think, it reacts. It is the smoke alarm. You cannot talk to it. You cannot tell it to calm down. Its job is to be on the lookout for the next threat. When it decides there is danger it triggers the fight/flight/freeze response. That prepares us to fight or flee. Or, possibly if we have an instant perception that we cannot escape, to freeze.

Fight or flight has many systems in the body. Besides sending more blood to the muscles and shutting down executive function in the brain, our hearts speed up. Blood glucose goes up. Blood pressure rises. We perspire. Digestion shuts down. There is a huge shift away from immune and other non-essential systems and into those that can help you get out of danger.

Other effects of trauma include some disconnection from broca's area of the brain which manages speech production among other things. Hence the limitations of just talking about a traumatic memory to defuse it.

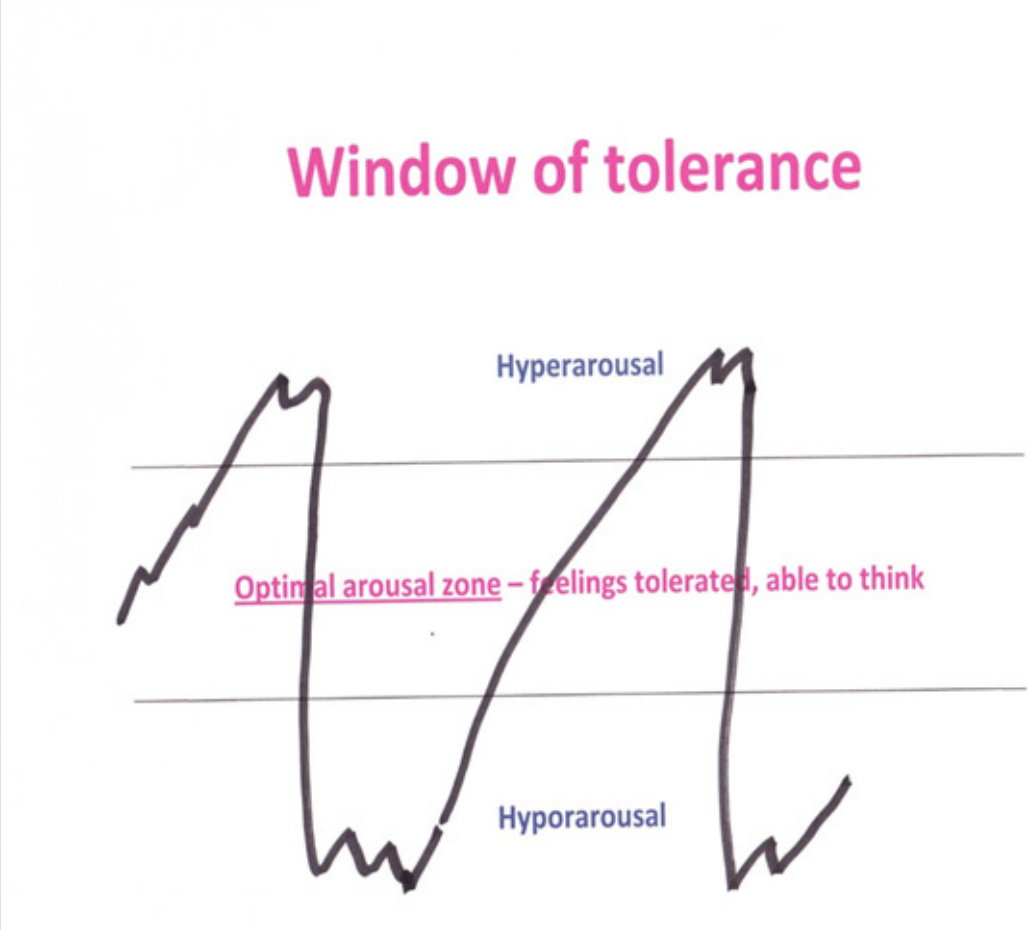
TRAUMA IS NOT JUST A PSYCHOLOGICAL EVENT. Flight/flight/freeze/flop affect systems all over the body.

THE WINDOW OF TOLERANCE

The window of tolerance is a model first devised by Dr Dan Siegel, founder of Interpersonal Psychobiology, and subsequently adopted by many of the major writers on trauma.

The window of tolerance is a useful mental model for therapists working in therapy with traumatized and other anxious clients' levels of arousal and how best to enable them to have control of them. We will return to using it later.

But while we are thinking about polyvagal theory, I just want to flag up how it relates to polyvagal theory. The diagram below shows how arousal states map on to different stress states.



Hyperarousal

Increased sensitivity

Emotional reactivity

Hypervigilance

Intrusive imagery

Disorganized cognitive processing

Impulsivity

Risk taking

Poor judgment

Racing thoughts

Self destructive behaviour

Increased sensitivity

<u>SYMPATHETIC FIGHT OR FLIGHT RESPONSE</u>

Optimal arousal zone

People can tolerate feelings and can think

Can integrate on cognitive, emotional, sensorimotor and energy levels

VENTRAL VAGAL SOCIAL ENGAGEMENT RESPONSE

Hypoarousal zone

DORSAL VAGAL IMMOBILIZATION RESPONSE

Relative absence of sensation

Numbing of emotions

Disabled cognitive processing

Shame, depression, collapse, numbing,feels dead, empty, not there, flat

Slowed cognitive functioning

Uses cognition to cut off from overwhelming emotions

Relative absence of sensation

Reduced physical movement

The window of tolerance is a useful mental model for working with trauma. It is also a useful tool to have available on a chart so you can discuss it with clients for whom it is appropriate.

Our aims are to

a) help clients to move into the optimal arousal zone to do therapy

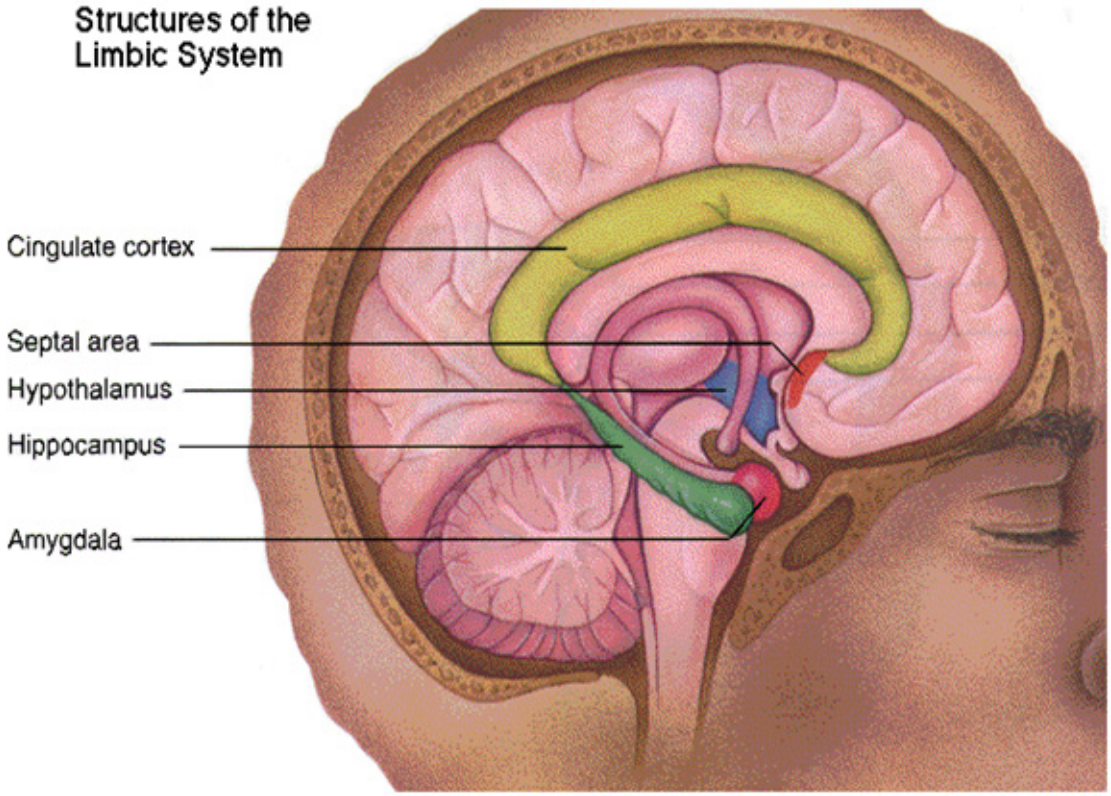
b) help clients learn to get themselves into it outside therapy

c) widen the optimal arousal zone

THE TRAUMTIZED BRAIN

As I have said it is the brain's job to keep us safe by noticing and evaluating danger in the environment around us and taking evasive action when it is necessary.

Beyond that seemingly simple statement is the network of systems of amazing complexity, some of which sits at the edges of our current understanding.



We have said that Perception starts with our senses, with the sights, sounds,

smells, touch sensations that give us information about the world around us. It is worth repeating that we unconsciously choose what sensory information we notice and consider. Our senses collect the information our brains ask them to, based on our past experiences and our default level of vigilance. In trauma victims, hyper vigilance is the default.

Ten times as many neurobundles going from brain to body as from body to brain means that we tell our senses what to notice ten times more than we just consider an unbiased assessment of what is around us. And the more hypervigilant we are the more we want to perceive and react to tiny hints of danger.

Normally, when the danger has gone, the body returns to its usual default mode. But when recovery is blocked in some way, people continue to feel arousal and agitation.

Bessel van der Kolk in one of the best books on trauma The Body Keeps the Score has a helpful way of describing the relevant brain systems to ourselves and to our clients. I find them a useful aid not only to understanding but also to remembering.

He uses **THE SMOKE DETECTOR, THE COOK, and THE WATCHTOWER**

THE COOK

The cook of this metaphor is the thalamus inside the limbic system. It is where information from the outside world lands and is collected into an integrated experience of "this is what is happening to me." This is then passed both to the smoke detector or amygdala, and, by a longer and slower route, to the prefrontal cortex, or rational brain. However, by the time the information reaches this rational part of the brain, it is already too late for a more reasoned interpretation such as that is not now, it was back then.

THE SMOKE DETECTOR

In this metaphor, the smoke detector is the amygdala, the pair of almond-shaped structures deep in the limbic, unconscious brain. It is involved in many of our emotions, especially those such as fear, and anger related to survival.

The amygdala reacts really fast to decide if input from our senses adds up to a survival threat. It gets some help in this from feedback from the nearby hippocampus, which compares current input with past experience and is also responsible for deciding what memories are stored and where they are stored in the brain.

It is the amygdala that sends a message to the hypothalamus to secrete stress

hormones such as adrenalin and cortisol to enable us to fight or flee from the threat

The amygdala becomes hyperactive in people who have experienced trauma which means it reacts swiftly and strongly not only to the actual present environment but to anything that reminds them of the trauma. That can be images, sounds, or feelings. But it can also be so subtle it is difficult to trace. It may be no more than a particular look on a face, a phrase.

So with a hyperactive amygdala, a person is subjected to cascades of stress hormones repeatedly both when that is relevant and when it is not.

THE WATCH TOWER

The watch tower in Van der Kolk's metaphor is the prefrontal cortex. It has executive capacities that enable us to look at what is going on and predict what will happen if we take certain action and make a conscious choice. The key word here is conscious.

Appropriately for a watch tower, it is situated just above the eyes. It enables us to over-ride automatic reactions preprogrammed into the emotional brain. We need it to have normal relationships not only with ourselves but with others. It is why we can handle frustrations such as being put on hold by a call centre without going into one. That is the good news.

The bad news is that in traumatized people the balance between the smoke detector and the watchtower is out of whack which makes it much harder to have control of emotions and urges. Strong emotions such as fear ramp up activity in the subcortical brain regions that deal with them and turns down the power in the prefrontal cortex.

WATCH TOWER V SMOKE ALARM

The key component of trauma therapy is getting a good balance between the smoke detector and the watchtower.

There are two ways to approach this - top down and bottom up. We need to know the difference.

<u>Top down</u> means ways to strengthen the watchtower's capacity to monitor the body's sensations. Mindfulness meditation is one way to do this for most of us. But mindfulness needs special considerations in clients who are traumatized. We will return to these later.

<u>Bottom up</u> means recalibrating the autonomic nervous system. One of the most potent ways to do this is through breath, one of the few body functions

that is under both conscious and autonomic control. Movement and touch can also be helpful here. We will look later at ways to do use this learning in therapy.

THE COOK – OR THALAMUS

The thalamus (or cook) breaks down in trauma so it does not do its usual job of integrating sensations from ears, eyes and skin and integrating them into autobiographic memory. That is why traumatic experiences are not remembered as a story with a beginning, middle and end but as a series of images, sounds and sensations with intense emotions attached to them.

It is because the floodgates are open and people with PTS do not have a filter to save them from some of the sensory overload, that they try to shut down as much as they do. If they cannot use drugs or alcohol to block out the world. One price they pay is that they also shut down the ability to experience pleasure and joy as well.

DEPERSONALIZATION

Another way another person might respond to trauma is by going numb, blanking their minds, and feeling nothing. This is often the response to adult trauma of someone who learned the skill early, blanking out of traumatic experiences in childhood.

Some people who initially respond to trauma with flashbacks later numb out.

This is a place for direct (though that does not necessarily mean immediate) EFT intervention. Using tapping on acupressure points can help people to bring up and notice bodily sensations. Another prescription for this part of the journey is rhythmic interactions with other people – like tossing a ball back and forth. Or tossing the tapping back and forth.

Desensitization is not enough. Our treatment goal should be to help clients live fully and securely in the present. That means bringing back online brain structures that deserted them when trauma overwhelmed them.

Desensitzation may make you less reactive to triggers. But if you cannot enjoy the ordinary pleasures of everyday existence , your life will still pass you by.

So I hope your takeaway from this section would be the following points to which we will be returning later:

- Trauma has different effects on different parts of the brain and hence our therapy needs to target different parts in different ways

- EFT is only part of this picture. It is a powerful trauma treatment,

especially when used in conjunction with other approaches.

• EFT can help us to be more aware of body sensations, to be better able to tolerate them, and to dampen them down them when they are too unpleasant to tolerate.

• EFT can help us to help clients reach an arousal zone where they have safety and a capacity to work with EFT and in other ways on the actual trauma memory and on other related negative emotions.

• EFT can disempower the stored negative emotional components of memories. We will look at how we do that in chapter 4.

• EFT can work with trauma memories in ways that have the least risk that the therapy will be retraumatizating for clients and of second.

IN THE BEGINNING

The evidence of the importance of early childhood experience to later physical and psychological health is overwhelming and indisputable. Trauma can start early and influence not just as by being traumatic experiences at the time but also can be a diversion or roadblock to normal healthy neurological, physiological and psychological development.

One of the most famous and convincing studies of the effect of early adverse experiences on later health and happiness is the Adverse Childhood Experiences (ACE) Study, which was one of the largest investigations ever conducted on the links between childhood maltreatment and later-life health and well-being. Between 1995 and 1997 It looked at 17,000 people in the US, and then and since has inspired more than 50 published scientific articles and more than 100 conference and workshop papers on its findings and its follow-ups.

In brief, the ACE Study findings were that childhood abuse, neglect and exposure to other traumatic stressors are not unusual. Two thirds of the people who took part in the study reported one of these adverse childhood experiences (ACEs) and one in five reported three or more.

The ACE score derived from these histories found that the more a person had experienced the higher the likelihood of a range of negative physical and psychological outcomes including alcoholism and alcohol abuse, depression, drug use, domestic violence and suicide.

Some physicians are beginning to realize that this is where the origins of physical conditions they are treating lie.

When an enterprising medical practice experimented with asking new patients on their intake assessment about their early adverse experiences they found that these patients had fewer consultations and needed fewer drugs than people who were not asked – even though the information was not followed up in any way. All that these patients had had was the chance to have their experiences acknowledged.

If this prevalence of early childhood suffering is still shocking, its historical context is even more so.

Leading trauma expert Bessel van der Kolk recalls in the Body Keeps the Score that in his early career, the standard psychiatrist textbook of the time said that father-daughter incest was a one in a million occurrence.

And it added "such incestuous activity diminishes the subject's chance of psychosis and allows for a better adjustment to the external world."

Since that original ACE study was done, there has been an increasing volume of other evidence of the importance of early experience to both early and later development.

Studies of attachment have increased understanding of the long-term effects of early experience for long-term development of relationships and of resilience in the face of what life later throws at us, especially of trauma.

The limbic emotional brain, especially the right side of it, comes ready prepared at birth for mother and newborn to bond instinctively. That is essential for the baby's survival. It is in that part of the brain that contains neuronal centres serving the survival instinct, memories, emotions and pathways for the sense of smell, important for survival. Knowing that has given us a much more nuanced understanding of how and why the earliest years are so crucial to development.

Attachment has become a buzz word across the whole range of schools of therapy in the last few years. And with good reason. It is absolutely key. It is inextricably bound up with trauma and its effects and its aftermath.

We are biologically designed to be social animals. We need to connect with other people. If we are left alone long enough with ample food and water on a desert island we will die.

And babies with too little of any variety of interaction in infancy fail to thrive. Deprivation dwarfism is the most extreme evidence of how too little

interaction of any kind actually stunts growth not only of the brain but of the whole body.

As neurological knowledge has been expanding rapidly, we now know that babies are born with a “fat” brain. They have the foundations for development in different directions and so can and survive in whatever environment they find themselves, whether it is loving or abusive or violent or chaotic. The connections not built on and developed by use are automatically pruned.

Thus, living in a troubled or unloving or inconsistently loving family does not just have a psychological effect. It has a neurological one as well.

In an ideal attachment experience, a baby connects with its primary caregiver not only to have needs such as dry nappies and feeds provided but to discover what it is to be soothed by the other. Over time, they internalize this and to so learn sooth themselves in interactions with others besides their initial primary caregivers.

As soon as a baby is born, it has functioning neurons. These are the brain cells discovered by accident in 1994 by two Italian researchers working on the brain functions of monkeys.

One great description of these neurons which we share with monkeys is “neural WiFi”. They are the neurons that explain how we do empathy, imitation, and synchrony. They are even involved in developing language.

Newborns not only have this “neural WiFi” from which they pick up the feelings of those around them but to start with they can see, in focus, only about 8 to 12 inches. This means they can see as far as the person holding them.

Newborns also already know the voice of their mother. They have been hearing it since before they were born.

And when they are handed to their mothers for skin-to-skin contact the physical feeling is the final element of this initial and crucial connection is in place.

Babies do not have the ability to regulate their own emotions. They do so and learn to do so by being in sync with their caregiver. Gradually this locus of control is internalized. With secure attachment they develop this crucial key factor for life-long ability to cope with challenges.

But if the early attachment experience is of unresponsive carers, or inconsistently responsive carers, or even abuse or violent carers, they are being conditioned not to cope with later difficulties but to experience challenges as a

trigger to react inappropriately or just to give up.

So, what happens in these earliest weeks and months will affect profoundly how someone later exposed to traumatic experiences will react at the time and their subsequent ability heal.

Dan Siegel, founder of Interpersonal Neurobiology, has coined the term "secure earned attachment" to describe how individuals deprived of an early experience of secure attachment with their initial primary caregivers can repair in later life by building a strong attachment relationship with a friend, a partner, or a therapist.

If this needs to be a goal of therapy with all clients for whom it is relevant, it is particularly so when we are working with trauma. If someone has a trauma history, they will have an especially pressing need to be able to self-soothe but may have the fewest resources to do so. Helping them build them has to be part of our agenda.

Trauma for clients who did not have a secure history of early attachment is a double whammy because they this lack this ability to self-soothe. When they are triggered, they will have less ability to take care of themselves than those who learned it at an early age.

They may also have had their ability to make social connections disrupted by their early experiences and may have a smaller and less close circle of friends. Having good social support lessens the likelihood that experiencing trauma will lead to post traumatic stress disorder and predicts a swifter recovery if it does.

This is a difficulty for all trauma victims. But if you are talking war trauma it can be even more of a difficulty. Evidence is that the more difficult an early childhood a service man or woman had, the more likely that war zone experiences will leave them with a post-traumatic stress legacy.

That is something that, as practitioners, needs to be understood. But we need to be sensitive in whether and how we share it with clients. I have seen comments in an Army chat room in which soldiers were saying something like: "And now they are saying we are not their (the service's) responsibility because it was not our war experience but our fathers who damaged us."

To complicate the plight of the traumatized veteran, some people are attracted to the services because they are, whether they consciously know it or not, looking for a new family to replace the one they did not really have or which did not really meet their needs.

Military training is geared to maximizing bonding. When this is part of the

original driver, and when veterans damaged by trauma group together as a mutual support group who experience other members as the only people who really understand what they are going through, they may have an unconscious desire to cling to the trauma's aftermath because it is a pre-requisite to belonging to the only group that really matters to them or where they feel they matter.

As good social support predicts less vulnerability to PTSD and better recovery it is generally good practice in therapy to encourage trauma victims to connect with and build a good social support network. But it is a more ambiguous situation when the social support brings with it a secondary gain that would be lost by recovering from PTSD.

A further attachment-related complication for trauma recovery is that people with a poor attachment history may have learned that it is safer to avoid being closely involved with people in any way.

Secure attachment, in which the primary caregiver is able to understand and meet the baby's needs, does not need to be perfect. It is better if it is not.

Caregivers are human, too. At times the infant/adult relationship will be disrupted by competing internal and external demands on the caregiver(s). Secure attachment can withstand the bond being ruptured and repaired. In fact, learning that it can be disrupted and repaired builds essential resilience.

It is comforting to realize that good attachment does not need perfect parents. Just good enough ones.

WORKING WITH TRAUMA

What we have done so far is to prepare the ground for the actual work of helping trauma clients to heal.

Before moving on to the practicalities, a brief word about the word "heal". I would never use and would strongly caution against using the word "cure" for a whole bunch of ethical, legal, and practical reasons. But to me "heal" is different. Heal covers any resolution that means someone can be okay with what has happened and where they are.

To be put it with starker clarity, if you were working with someone with terminal cancer they could be "healed" but still die. The healing would be acceptance, peace – whatever it needed to be for that individual to be okay with themselves and with what was happening. So, when I use heal that is what I mean.

But if you do use the word "heal" with clients or student just make sure they

are clear what you mean by it.

MEMORY CATEGORIES

What is memory? And how does understanding the different kinds of human memory give us a better way to dealing with traumatic memories and their effects? I want to start with a few things we do not do in my view of trauma therapy:

We do not erase the memory of trauma. Our goal is that people can remember something that happened as an event that happened, and to which they can now go if they chose without an instant and inevitable overwhelm of mostly negative sensory sensation and emotions. That going to the memory is now a choice – it no longer hijacks them. And that whatever feelings do still come up when they recall the event or events, they can manage and tolerate.

Nor do we try to have people change the actual story of a memory. We might think it would be better for them if the story had had a different ending. It might feel better in the short term. But:

- We cannot know what would be "better" for someone else.
- And in any case, people are the sum of their memories, their histories.

Mess with a memory and you are messing with identity.

Nor do we set out to recover memories. To attempt to do so is to run two big risks:

- We may remove repression that the person's unconscious mind knows it is not yet safe for them to access. Repression may still be a useful defence.
- We may unintentionally implant or be a catalyst for the invention of false or distorted memories.

The unconscious mind can be pretty obliging if it gets the idea that something would be helpful. The highest risk of implanting false memories is probably working with hypnosis. But people go in and out of trance all the time, in and out of therapy. People may be in the particularly suggestible brain pattern of hypnosis without your intending or realizing it.

And even if they are not, clients will often be seeking answers as well as relief from their emotional pain so may latch on to any suggestion or perceived suggestion from their therapist, or from what they have read, or from other members of a therapy or self-help group.

Unfortunately, too, we tend to think that the more strongly we feel something

the more it must be or is likely to be true. Not so.

So, it is important that we do not do anything to encourage clients to recover repressed memories.

However, people may spontaneously begin to recover scraps of repressed memory before or during therapy. Sometimes something external is the trigger for the beginning of the process of recovering a genuine memory or series of memories.

Some victims of sexual abuse have begun to remember it after reading testimonies of others who were abused by the same person or in similar circumstances. Bessel van der Kolk, in The Body Keeps the Score, recounts an example of someone who started to recover memory fragments after a phone conversation with his girlfriend who told him that a priest he had known as a child had been accused of sexually assaulting someone else.

It was Van der Kolk who convinced a federal circuit court judge in Boston that it was common for traumatized people to lose all memories of an event, only to regain it in bits and pieces as a much later date.

Often the cost of repression has been high. A person who has repressed such a memory or memories may have a history of depression without knowing where it started, or may drink too much, or eat too much, or shop too much or use recreational drugs or have other addictive behaviours in an attempt to self-medicate negative feeling they do not understand.

Of course, there is always a danger that someone will present with invented copycat memories. I will not challenge if I suspect that to be the case because:

If I am wrong and I appear not to believe the client, I risk losing rapport

- Ditto if I am right
- I would risk piling on another level of trauma. Often part of traumatic experiences, and sometimes people say it is the worst part, is that they did tell someone at the time and were not believed.
- If a memory is fabricated unconsciously, it will be a metaphor for something that did happen.
- If a memory is fabricated consciously, the need to fabricate will be a symptom of another problem.

So, we need always to work with what clients bring whether it is no recall, recall in fragments, or even invented memory. Just start where they are

and go with them as they discover where that leads them.

It makes more sense to start with their awareness of body sensations and how to work with them before we go anywhere near specific memories anyway.

One other important reminder about memory. Clients may think memory is like an audio or video recorder and that what they remember is what happened. We need to make sure that they understand that every time we retrieve a memory, we edit it in some way, and what we put back into memory store is never exactly what we took out.

That is partly why when families get together and talk about big events in their collective past, they have different stories and cannot understand how the others have remembered it so differently. The other part of mechanism that creates this divergence is, of course, that people have different perceptions of what is happening at the time.

So, memory is labile. And while that can make access to trauma slippery, it is also a therapeutic opportunity.

I am sure you are all familiar with the movie technique, the tearless trauma and storytelling as ways to work with specific trauma memories. I regard them as a group as EFT's most useful work horses. Each involves retrieving a memory and then deliberately influencing the version of it that goes back into storage.

I know some people do them or use the terminology about them in slightly different ways, so I will define what I mean by them a bit down the line, so we are all singing from the same hymn sheet.

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Different explanations have been put forward for why something as seemingly simple as the movie technique can make the difference it often does in a traumatic memory.

Tapping, whatever the focus, does produce some physical relaxation of the body.

Memories should be something that enables us to draw on past experiences so we can function more effectively in the present and have a context for new experiences. We often see something very different from this ideal in our trauma clients.

Memory is dynamic and changing. Or should be. Traumatic memories stop us from moving forward and updating because, unlike other memories, they remain fixed and frozen.

Memory divides into **Implicit** and **Explicit** and they in turn have subcategories.

Explicit or declarative memory is conscious, and it is linear. It is detailed conscious remembering. It enables us to retell the story of a memory. It is often told in a logical order and is put together in the cerebral cortex of the brain. It is what most people mean when they think of memory.

In **explicit memory** we have explicit episodic, that comes online when we are a bit past our third birthdays, when the hippocampus comes online in the midbrain. Explicit episodic memory is autobiographical but often has a sort of vague dreamy quality. So, we might remember a family holiday happened but not remember a lot of detail about it, other than some of the feeling about it.

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Babies do not have the ability to regulate their own emotions. They do so and learn to do so by being in sync with their caregiver. Gradually this locus of control is internalized. With secure attachment they develop this crucial key factor for life-long ability to cope with challenges.

But if the early attachment experience is of unresponsive carers, or inconsistently responsive carers, or even abuse or violent carers, they are being conditioned not to cope with later difficulties but to experience challenges as a trigger to react inappropriately or just to give up.

So, what happens in these earliest weeks and months will affect profoundly how someone later exposed to traumatic experiences will react at the time and their subsequent ability heal.

Dan Siegel, founder of Interpersonal Neurobiology, has coined the term “secure earned attachment” to describe how individuals deprived of an early experience of secure attachment with their initial primary caregivers can repair in later life by building a strong attachment relationship with a friend, a partner, or a therapist.

If this needs to be a goal of therapy with all clients for whom it is relevant, it is particularly so when we are working with trauma. If someone has a trauma history, they will have an especially pressing need to be able to self-soothe but may have the fewest resources to do so. Helping them build them has to be part of our agenda.

Trauma for clients who did not have a secure history of early attachment is a double whammy because they lack this ability to self-soothe. When they are triggered, they will have less ability to take care of themselves than those who learned it at an early age.

They may also have had their ability to make social connections disrupted by their early experiences and may have a smaller and less close circle of friends. Having good social support lessens the likelihood that experiencing trauma will lead to post traumatic stress disorder and predicts a swifter recovery if it does.

This is a difficulty for all trauma victims. But if you are talking war trauma it can be even more of a difficulty. Evidence is that the more difficult an early childhood a service man or woman had, the more likely that war zone experiences will leave them with a post-traumatic stress legacy.

That is something that, as practitioners, needs to be understood. But we need to be sensitive in whether and how we share it with clients. I have seen comments in an Army chat room in which soldiers were saying something like: "And now they are saying we are not their (the service's) responsibility because it was not our war experience but our fathers who damaged us."

To complicate the plight of the traumatized veteran, some people are attracted to the services because they are, whether they consciously know it or not, looking for a new family to replace the one they did not really have or which did not really meet their needs.

Military training is geared to maximizing bonding. When this is part of the original driver, and when veterans damaged by trauma group together as a mutual support group who experience other members as the only people who really understand what they are going through, they may have an unconscious desire to cling to the trauma's aftermath because it is a pre-requisite to belonging to the only group that really matters to them or where they feel they matter.

Good social support predicts less vulnerability to PTSD and better recovery. So, it is generally good practice in therapy to encourage trauma victims to connect with and build a good social support network. But it is a more ambiguous situation when the social support brings with it a secondary gain that would be

lost by recovering from PTSD.

A further attachment-related complication for trauma recovery is that people with a poor attachment history may have learned that it is safer to avoid being closely involved with people in any way.

Secure attachment, in which the primary caregiver is able to understand and meet the baby's needs, does not need to be perfect. It is better if it is not.

Caregivers are human, too. At times the infant/adult relationship will be disrupted by competing internal and external demands on the caregiver(s). Secure attachment can withstand the bond being ruptured and repaired. In fact, learning that it can be disrupted and repaired builds essential resilience.

It is comforting to realize that good attachment does not need perfect parents. Just good enough ones.

WORKING WITH TRAUMA

The trauma modules we have done so far prepare the ground for the actual work of helping trauma clients to heal.

Before moving on to the practicalities, a brief word about the word "heal". I would never use and would strongly caution against using the word "cure" for a whole bunch of ethical, legal, and practical reasons. But to me "heal" is different. Heal covers any resolution that means someone can be okay with what has happened and where they are.

To be put it with starker clarity, if you were working with someone with terminal cancer they could be "healed" but still die. The healing would be acceptance, peace – whatever it needed to be for that individual to be okay with themselves and with what was happening. So, when I use heal that is what I mean.

But if you do use the word "heal" with clients or student just make sure they are really clear what you mean by it.

MEMORY CATEGORIES

So, what is memory? And how does understanding the different kinds of human memory give us a better way to dealing with traumatic memories and their effects?

Memories should be something that enables us to draw on past experiences so we can function more effectively in the present and have a context for new experiences. We often see something very different from this ideal in our trauma clients.

Memory is dynamic and changing. Or should be. Traumatic memories stop us from moving forward and updating because, unlike other memories, they remain fixed and frozen.

Memory divides into Implicit and Explicit and they in turn have subcategories.

Explicit or declarative memory is conscious, and it is linear. It is detailed conscious remembering. It enables us to retell the story of a memory. It is often told in a logical order and is put together in the cerebral cortex of the brain. It is what most people mean when they think of memory.

In explicit memory we have explicit episodic, that comes online when we are a bit past our third birthdays, when the hippocampus comes online in the midbrain. Explicit episodic memory is autobiographical but often has a sort of vague dreamy quality. So, we might remember a family holiday happened but not remember a lot of detail about it, other than some of the feeling about it. In the last module I looked at the way implicit memory starts early – probably pre-birth- and encodes memories out of conscious awareness as emotional experiences, body feelings, pictures, perceptions.

Later when experiences trigger implicit memories, we interpret the feeling as something happening right now, even though it may be a triggered memory of something that happened decades ago.

We said that from these experiences the amygdala (or smoke alarm) will have developed some general understanding about how we feel the world works. These implicit pre-language memories create how we expect life to be.

From implicit emotional memories we will also have devised procedural implicit memories or action patterns. Those early experiences stored in emotional implicit memory will have prompted us to devise automatic behaviours when we feel emotions attached to them again.

Implicit emotional memory colours our perceptions and actions in ways that tend to reinforce what we have already concluded. They reflect that what we think is just the way things are.

When an implicit emotional memory is triggered it will turn on automatically the procedural implicit memory or action pattern that grew out of it. So, when we are working with trauma, we need not only to detach the emotion from implicit memory but also to unlink it from its automatic action pattern.

There are three categories of these procedural patterns. They are

Learned motor actions. This covers such things as the fact that once you

learn to ride a bike your body never forgets how to do it.

Emergency actions. When we meet a situation in which we are or perceive we are in real danger we will do what we did last time. It obviously worked. We survived. So that, generally, will be fight/flight/freeze. And that needs to be noted as an important part of the formation of subsequent trauma aftermath.

We can feel an old feeling, and have it trigger an old pattern of response without even realizing what is going on.

Remember that we have an evolutionary bias towards false positives. Evolution has favoured the inclusion in the on-going gene pool of the person who spotted the lurking tiger in the grass first and ran first and fastest.

Trauma resolution involves breaking that connection. We no longer need to run from tigers.

Active blueprints for living organisms. These include when to approach or avoid.

One important thing to remember about implicit memory is that when our day-to-day experience activates these memories from it, they have no time dimension. This means we interpret the feeling or emotion or perception or urge as being caused by something happening right now, even though we may actually be replaying something that happened years ago.

So, the original experience is recreated in the present over and over. And if it was negative, the earlier it happened the more powerful its influence will be both because the earlier in our lives the more impressionable we will have been and the longer ago the more replay repetitions it is likely to have had.

Between about 12 and 18 months the circuits of the amygdala are sufficiently differentiated to make the next linkage. Now, the hippocampus and the middle prefrontal region starts to come online, and explicit memory begins to become available.

EXPLICIT MEMORY

Explicit memory also has subcategories – episodic (sometimes called autobiographical) and declarative.

Episodic explicit memory is more conscious remembering than implicit memory but less than declarative. Episodic explicit memory is vaguer. In it we may have stored some scenes and feelings from a road trip we went on with

our family when we were quite young, and perhaps some incident from it. Or that something happened, but not what it was.

Generally, our episodic memories go back to the age of about three and a half but some people do have earlier ones for which they have been able to find reliable external verification. For example, one client of mine was able to describe a shop outside which his mother used to leave his pram. His mother knew and was able to tell him that that shop was pulled down when he was two.

Declarative explicit memory enables more deliberate, logical and linear recall of events in our life stories. It allows us to retell a story in logical order from start to finish.

So how might a trauma memory might be understood in terms memory types?

Let's look at a simple example to see how that clarifies the links and how an awareness of different memory categories can help us to work with a trauma victim.

A recurring client story in my practice has been people for whom presenting to an audience or even to a group of colleagues is an ordeal. Often it is terrifying ordeal. Sometimes even being in a meeting where they think they might be asked a question can turn them into a bundle of nerves.

They have usually been intelligent people with good grasp of their subjects who know in theory what they need to do to give a good presentation. But even when they are presenting to a group who they know are already on their side and online with their message they find it hard to breathe, their legs turn become weak and turn to jelly, they cannot think. They may feel they have ceased to be real or are outside their bodies looking on. They may even feel they are going to die.

So, what is going on here?

They are responding as if they are in imminent danger, under great threat, when they obviously are not and when they know in their rational minds they are not.

My number one therapy rule is that no two clients' problems are necessarily alike. People may have identical symptoms in the same situation. But the story behind them will be unique to each client. Their memories will be different.

But let's look at one typical client who has these feelings. She is experiencing implicit memories that are breaking through from unconscious awareness because the situation is provoking the same physiological and emotional

feelings as did something that happened to her once before. There is something perceived as similar enough about the then and the now experiences for all the feelings that belong to that old memory to activate. And this will feel not like something from the past but like something that is happening right now. That is how implicit memory works.

So, the procedural explicit memory, the action pattern, linked to it will kick in.

It might have been to flee. And to avoid such situations in the future at all costs.

Now, as an adult, the cost of refusing to present really might be high. It might be a bar to promotion, for example. It is not unusual in my experience for a person with this deep dread of presenting to refuse to seek or to accept promotion because they know it would have to involve presentations and the feelings that go with them.

In the implicit memory that the current situation is accessing will be experience in which the person had to do something that involved speaking out or in some way "performing" in front of others or something that has some similarity to that in their perception.

The previous event might have been being made to read to the class when they could not read aloud competently. Perhaps they felt everyone was staring at them and thinking how stupid they were. Perhaps their classmates actually laughed at them.

People with dyslexia often have a lot of such traumatic school memories to get past in their adult lives.

Or it might have been playing the piano in the school concert and losing the place in the music. Perhaps running off the stage.

When that emotional implicit memory feeling is triggered, a person usually has absolutely no idea what they are really reacting to. But the automatic action pattern set up when this was first happened, will kick in. That is quite likely to be the fight flight response with the physical changes conducive to running or fighting but far from ideal for standing still making a presentation. What they are experiencing is the effects of a cascade of adrenalin and other stress hormones, altered blood flow, halted digestion, and executive brain shutdown readying them for escape when what they need is a focussed brain and a calm body.

That seemingly miraculous ability EFT has to take us where we need to go often crops up in situations like these.

Start to tap on a recent memory of a presentation that went wrong and we may find a client say: “I do not know why my mind has wandered but I have been thinking about the time when… “

Therapy gold. That is almost certainly the original trauma. Make a note of it.

It is usually advisable – but use your own in-the-moment clinical judgement - to work first on the recent negative trauma experience and detach the negative emotions from it before you go back to the original trauma.

If a client has a lot of negative current presenting memories, I might even use my favourite trio – the first time you remember, the worst time you remember and the most recent time or most recent really bad time.

Once you have tapped on those, it is unlikely that it will still trigger the same action pattern as it did before. If it seems to, it will not be doing it in the same way. But it is also worth considering whether the expectation of the old habit is a self-fulfilling prophecy.

You might also need to tap on something like: “Even though a part of me still expects…

Another option would be to ask the client to create a make-believe movie in which they presented effortlessly and confidently and got a good reception. The emotions and objections that come up will be relevant potential tapping targets. Once they can run that movie and have it gone well, they will now have a positive memory to draw on.

Don’t forget the unconscious mind cannot tell fact from fantasy.

In a situation like this, once you have finished dealing with a representative sample of the current and recent presentation memories you can go back to the original one that came up. Otherwise it will come up to bite them in other situations.

MEMORY RECONSOLITATION

We have talked about how we change memories in everyday life and in EFT by bringing them up, editing them in some way, and putting back into store the new version.

A perhaps more sophisticated understanding of what is going on when EFT has the dramatic effect, we know it does on traumatic memories comes from the memory consolidation work of Ecker and others. They look at how what were previously thought to be permanent memories can be brought up, made labile again, and changed at the level of chemical synapses in the brain.

This is an example of neuroplasticity in action.

If you want to study their work further, read *Unlocking the Emotional Brain: Eliminating Symptoms at Their Roots Using Memory Reconsolidation by Eckert et al. (2012).*

They have devised and teach a complete therapy approach in which they aim to use what they say is the brain's mechanism for updating existing learnings with new ones. Studies and clinical experience seem to be confirming that their sequence of steps is able to unlock and make available for change highly emotional experiences in the past.

Here is a simplified outline of their steps. First, the emotional memory or learning must be vividly accessed. Second, we have to activate what they call "a juxtaposition experience" that contradicts the implicit models or conclusions drawn from the original experience. Third, the juxtaposition pairing must be repeated several times.

So how does EFT map onto this model? Or perhaps how does this model map onto EFT?

Very well, as David Feinstein, co-author with Gary Craig of The promise of energy therapy and a leading advocate for the mainstream acceptance of energy psychology, has argued in The Neuropsychotherapist.(Issue #10 January 2015)

People often ask why we focus on the negative in EFT. We say it is because we want the relevant arousal of the energy system present to tap on. It means, when we are working with traumatic memories, we ask people to bring the event to mind and use a reminder phrase to keep it there.

Because of the way implicit memory works that means we also bring up the belief and the linked behaviour. This might be, for example, fear coupled with a conviction that situations are dangerous and must be avoided, or the world is unsafe, and we must always be on high alert.

Now we tap on acupressure points and when we do it reduces limbic arousal, so feelings change while the client's attention is on the traumatic memory or trigger. We are tapping while focussing on the emotion attached to the memory, but the fear response is no longer present. Steps one and two of memory consolidation are being covered.

When we repeat, as we do, we are doing step three.

HOW HELPFUL IS IT TO TALK?

After 9/11 few survivors seemed to opt for psychoanalytic or cognitive behavioural therapy which were expected to be the main interventions and for which an outcome research project had been set up. So in in 2002 a psychiatrist and a group of medical students did a survey of 225 people who escaped from the Twin Towers to find out where they did get help.

Survivors credited acupuncture, massage, yoga and EMDR in that order. People seemed drawn most to therapies that they thought would relieve the physical legacy of trauma. At least in the short term, there seemed to be a lack of interest in talk therapy.

Therapy has a long tradition of believing that we can talk our way out of everything negative. But how true is it

In my experience, many clients need to be heard and value it. With some clients it becomes a challenge to move them beyond talking.

But most of us would recognize that our memory of 9/11 is not of words but of pictures – the images that were played over and over on television and, for many people, played over and over in their own heads thereafter.

The plane crashing into the tower… people running… people jumping.

Neuroscience now tells us that we have two distinct self-awareness systems - one that keeps track of ourselves over time and one that registers how we are in the present moment. They do not communicate well with one another.

And maybe it is a design flaw that the language centre of the brain is about as far as possible from the centre for experiencing oneself. Only this latter system, in the medial prefrontal cortex, can influence the emotional brain.

Before a traumatized person comes into therapy, and outside it, they have probably discovered that friends and family run out of patience with people stuck in trauma. So, they may tend to withdraw from other people. They may have edited their stories to versions they think will be least likely to provoke rejection.

This is something to bear in mind when people do tell you their trauma stories. Often people to tell them in a way that seems distanced, numbed – or as if they have told it so many times, they have become bored with it. Don't let it fool you.

What we need to do is what Peter Levine has termed "pendulate" – to go in and out of the story and the feelings it brings up with resources we have set up with and for them to help them manage the feelings.

These can be grounding techniques such as breathing or deliberate, conscious awareness of a particular part of the body to bring them back into a better place when they become terrified, or numb, or mute. Or, of course, we can use tapping.

We pendulate to prevent them from be overwhelmed

Another misapprehension some therapists have about language is that it can be the vehicle for correcting thoughts that do not make sense. Challenging dysfunctional thinking is the cornerstone of cognitive therapy.

Trauma victims do often have irrational beliefs. “If I had not panicked, I could have rescued him.” Or “I should not have deserved to survive when others did not. “ Or “if I had not fainted, I could had saved myself.”

Of course, it is useful to use your understanding of the physiology of trauma responses to add in new information for clients to integrate into their understanding. But it is just part of the overall picture. On its own, it will make little difference.

Bessel van der Kolk suggests regarding these irrational thoughts as cognitive flashbacks, and not to try to argue them away any more than you would argue with visual flashbacks.

Freud talked about the memory of trauma being like a splinter that causes an infection in the body. In this metaphor, the splinter is not the problem so much as the body’s reaction it. It is the reaction that we need to work with. I think with EFT we do both.

When we tap on body sensations that come up in the wake of trauma, or as a person attempt to tell the story of trauma and their thoughts about it, we are dealing with the infection, not the splinter. For the splinter we need to think movie technique, tearless trauma etc.

But before we do, we can use EFT to sneak up on doing so. So not only would we invite people to dip a little into the feelings of a remembered trauma and come out again, and help them to manage the feelings with tapping and in other ways, but we can use tapping to take some of the angst out of the whole process.

“Even though I cannot even think about it…

“Even though I cannot even think about talking about it…

“Even though when I think about it get this heavy black ball in the pit of my stomach…”

“Even though I do not even want to go there…”

The variations are endless, and the best choices are the ones that reflect what the client is saying to you. . Or , second best, our best guess about what they experiencing with an explicit and insistent invitation to contradict or edit us.

There is a preframe on one of Gary Craig’s DVDs that I really like. He talked about saying things as they come into his head and “some are garbage, and some are gold.” He says he cannot tell which is which, so it is up to the person he is working with, who does know, to tell him. I like to borrow that.

MEMORY CONSOLIDATION

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RAPPORT

EFT Founding Master

I want to start with a few things we do not do in my view of trauma therapy:

We do not erase the memory of trauma. Our goal is that people can remember something that happened as an event that happened, and to which they can now go if they chose without an instant and inevitable overwhelm of mostly negative sensory sensation and emotions. That going to the memory is now a choice – it no longer hijacks them. And that whatever feelings do still come up when they recall the event or events, they can manage and tolerate.

Nor do we try to have people change the actual story of a memory. We might think it would be better for them if the story had had a different ending. It might feel better in the short term. But:

- We cannot know what would be "better" for someone else.
- And in any case, people are the sum of their memories, their histories. Mess with a memory and you are messing with identity.
- Nor do we set out to recover memories. To attempt to do so is to run two big risks:
- We may remove repression that the person's unconscious mind knows it is not yet safe for them to access. Repression may still be a useful defence.
- We may unintentionally implant or be a catalyst for the invention of false or distorted memories.

The unconscious mind can be pretty obliging if it gets the idea that something would be helpful. The highest risk of implanting false memories is probably working with hypnosis. But people go in and out of trance all the time, in and out of therapy. People may be in the particularly suggestible brain pattern of hypnosis without your intending or realizing it.

And even if they are not, clients will often be seeking answers as well as relief from their emotional pain so may latch on to any suggestion from their therapist, or from what they have read, or from other members of a therapy or self-help group.

Unfortunately, too, we tend to think that the more strongly we feel something the more it must be or is likely to be true. Not so.

So, it is important that we do not do anything to encourage clients to recover repressed memories.

However, people may spontaneously begin to recover scraps of repressed memory before or during therapy. Sometimes something external is the trigger for the beginning of the process of recovering a genuine memory or series of memories.

Some victims of sexual abuse have begun to remember it after reading testimonies of others who were abused by the same person or in similar circumstances. Bessel van der Kolk, in The Body Keeps the Score, recounts an example of someone who started to recover memory fragments after a phone conversation with his girlfriend who told him that a priest he had known as a child had been accused of sexually assaulting someone else.

It was Van der Kolk who convinced a federal circuit court judge in Boston that it was common for traumatized people to lose all memories of an event, only to regain it in bits and pieces as a much later date.

Often the cost of repression has been high. A person who has repressed such a memory or memories may have a history of depression without knowing where it started, or may drink too much, or eat too much, or shop too much or use recreational drugs or have other addictive behaviours in an attempt to self-medicate negative feeling they do not understand.

Of course, there is always a danger that someone will present with invented copycat memories. I would not challenge if I suspect that to be the case because:

- If I am wrong and I appear not to believe the client, I risk losing rapport
- Ditto if I am right

- I would risk piling on another level of trauma. Often part of traumatic experiences, and sometimes people say it is the worst part, is that they did tell someone at the time and were not believed.
- If a memory is fabricated unconsciously, it will be a metaphor for something that actually did happen.
- If a memory is fabricated consciously, the need to fabricate will be a symptom of another problem.

So, we need always to work with what clients bring whether it is no recall, recall in fragments, or even invented memory. Just start where they are and go with them as they discover where that leads them.

It makes more sense to start with their awareness of body sensations and how to work with them before we go anywhere near specific memories anyway.

One other important reminder about memory. Clients may think memory is like an audio or video recorder and that what they remember is what happened. We need to make sure that they understand that every time we retrieve a memory, we edit it in some way, and what we put back into memory store is never exactly what we took out.

That is partly why when families get together and talk about big events in their collective past, they have different stories and cannot understand how the others have remembered it so differently. The other part of mechanism that creates this divergence is , of course, that people have different perceptions of what is happening at the time.

So, memory is labile. And while that can make access to trauma slippery, it is also a therapeutic opportunity.

I am sure you are all familiar with the movie technique, the tearless trauma and storytelling as ways to work with specific trauma memories. I regard them as a group as EFT's most useful work horses.

I know some people do them or use the terminology about them in slightly different ways, so I will define what I mean by them a bit down the line, so we are all singing from the same hymn sheet.

But first it would be useful here to have a slightly more depth look at what different types of

Different explanations have been put forward for why something as seemingly simple as the movie technique can make the difference it often

does in a traumatic memory.

Tapping, whatever the focus, does produce some physical relaxation of the body.

ADULT TRAUMA

Module 3

Working with trauma

The trauma modules we have done so far prepare the ground for the actual work of helping trauma clients to heal.

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To be put it with starker clarity, if you were working with someone with terminal cancer they could be "healed" but still die. The healing would be acceptance, peace – whatever it needed to be for that individual to be okay with themselves and with what was happening. So, when I use heal that is what I mean.

But if you do use the word "heal" with clients or student just make sure they are really clear what you mean by it.

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The unconscious mind can be pretty obliging if it gets the idea that something would be helpful. The highest risk of implanting false memories is probably working with hypnosis. But people go in and out of trance all the time, in and out of therapy. People may be in the particularly suggestible brain pattern of hypnosis without your intending or realizing it.

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However, people may spontaneously begin to recover scraps of repressed memory before or during therapy. Sometimes something external is the trigger for the beginning of the process of recovering a genuine memory or series of memories.

Some victims of sexual abuse have begun to remember it after reading testimonies of others who were abused by the same person or in similar circumstances. Bessel van der Kolk, in *The Body Keeps the Score*, recounts an example of someone who started to recover memory fragments after a phone conversation with his girlfriend who told him that a priest he had known as a child had been accused of sexually assaulting someone else.

It was Van der Kolk who convinced a federal circuit court judge in Boston that it was common for traumatized people to lose all memories of an event, only to regain it in bits and pieces as a much later date.

Often the cost of repression has been high. A person who has repressed such a memory or memories may have a history of depression without knowing where it started, or may drink too much, or eat too much, or shop too much or use recreational drugs or have other addictive behaviours in an attempt to self-medicate negative feeling they do not understand.

Of course, there is always a danger that someone will present with invented copycat memories. I would not challenge if you I suspect that to be the case because:

- If I am wrong and I appear not to believe the client, I risk losing rapport
- Ditto if I am right
- I would risk piling on another level of trauma. Often part of traumatic experiences, and sometimes people say it is the worst part, is that they did tell someone at the time and were not believed.
- If a memory is fabricated unconsciously, it will be a metaphor for something that actually did happen.
- If a memory is fabricated consciously, the need to fabricate will be a symptom of another problem.

So, we need always to work with what clients bring whether it is no recall, recall in fragments, or even invented memory. Just start where they are and go with them as they discover where that leads them.

It makes more sense to start with their awareness of body sensations and how to work with them before we go anywhere near specific memories anyway.

One other important reminder about memory. Clients may think memory is like an audio or video recorder and that what they remember is what happened. We need to make sure that they understand that every time we retrieve a memory, we edit it in some way, and what we put back into memory store is never exactly what we took out.

That is partly why when families get together and talk about big events in their collective past, they have different stories and cannot understand how the others have remembered it so differently. The other part of mechanism that creates this divergence is , of course, that people have different perceptions of what is happening at the time.

So, memory is labile. And while that can make access to trauma slippery, it is also a therapeutic opportunity.

I am sure you are all familiar with the movie technique, the tearless trauma and storytelling as ways to work with specific trauma memories. I regard them as a group as one of EFT's most useful work horses and use them frequently with clients in a very basic way.

I know some people do them or use the terminology about them in slightly different ways, so I will define what I mean by them a bit down the line so we are all singing from the same hymn sheet.

But first it would be useful here to have a slightly more depth look at what different types of

Different explanations have been put forward for why something as seemingly simple as the movie technique can make the difference it often does in a traumatic memory.

Tapping, whatever the focus, does produce some physical relaxation of the body.

What do you do with the imagery? Pic child sex abuse black or red – black no love no safety red anger.

If redraw pic as should have been – go for their personal nurturing colours

WORKING WITH TRAUMA

The first requirement for working with trauma is the same as it is for working with a client with any issue – RAPPORT. But with trauma clients it is an even more crucial and tricky relationship to establish and maintain.

The finding from a meta-analysis by John Norcross of all therapy outcome studies is that the best predictor of a positive outcome is what he called PRESENCE which he defined as the ability to be empathetic to our internal world, actively seek feedback, and being open to it rather than defensive.

To me that says "and don't rush in." Don't start with immediate machine gun salvo of tapping. New therapists often feel the urge to. It takes time to appreciate the value of listening deeply. It is not, as newbies often feel, doing nothing.

As you give clients time and space to tell their stories, and that means the stories of them, not just the stories of their traumas, you are listening at multiple levels. You are listening with your left brain, for the cognitive content. You are ordering it especially by listening for mentions or hints of past trauma events of situations and relationships to note in the client's trauma history.

You are listening with your right brain for things they may not be aware they are telling you. The unconscious mind will often reveal the information they are not consciously disclosing, and may not even be consciously aware of, in metaphors. Listen for them. And note down words or phrases that strike you as interesting or out of character or just somehow catch your ear.

Even if they do not make sense at the time, it is fascinating how often down the line you will realize they are somehow key. In fact, if you feel therapy is stuck and do not know why or what you are missing it is always worth going back to the first session to see if there was a clue there the significance of which you did not get at the time.

Listen for what clients are not saying.

And listen for changes of breathing or intonation as clients tell you their story.

Use your eyes. Is there any revealing body language also giving you information from their unconscious mind? It might be no more subtle than telling you how they are really up for change while they are while literally digging their heels into your carpet. But it might not.

I have seen clients doing that. You probably have, too.

When you are going to be working explicitly with trauma, and even if you do

not know you are, watch particularly for anything that might be a truncated trauma response. If someone wanted to run but could not, you might pick up minute movements in their feet. Or if they wanted to punch and did not dare, ditto fist. Or if there is a slight movement towards looking over a shoulder as they tell of a traumatic attack, note that too.

They are cues you need to return to. Down the line you will want to decide together how to work with them. They could be clues that unlock aspects of trauma memories not otherwise available to conscious recollection. They may be tappable – "Even though I did not run…." or "Even though I could not run…" for example.

Or if you notice they almost start to look over one shoulder you might want to explore this later by asking the client something like: "Just look over your shoulder and see what happens when you do."

Whether it is a memory or a feeling, it could be a useful tapping focus.

Use your own gut. Notice what happens in your gut as you and the client attune. This it is not about you. But it is about what you pick up unconsciously about your client. It is where empathy is most likely to be experienced.

Hopefully you have done and keep doing your personal peace plan - working systematically through your own negative memories - to keep the potential intrusion of your own stuff to a minimum. And hopefully you have a technique to park it until after the session if something does come up for you.

I don't know if it is just superstition or a testable truth (as far as I know not systematically tested) but most of us have had the experience of seeming to attract what we ourselves need to work on. When this happens, we are even more likely to be triggered by things our clients tell us.

This means we might be tempted to think we understand what they are telling us because we have experienced it, too. We have not. We have experienced what we have experienced. We can only know what clients have by asking them and listening to them.

Your role here is empathy, not sympathy. You want to get as far as you can into the world of the client. That is your shared workplace. And one of the ways to maximise our ability to have empathy is mindfulness meditation which can also hone our ability for deep attention. The more you are aware of your own bodily sensations the more you can tune in to other people's emotional states.

Studies at UCLA and Harvard show there are actual structural changes in the brains of people who practice mindfulness meditation and they are in those

parts of the brain we need to support empathy with other people. The neural circuits we are strengthening are the same circuits we need using to tune in to the internal world of someone else.

Although I said earlier don't rush into tapping, I think the exception to that is tapping on the side of the hand (what we used to call the karate chop) in which a client just taps on the fleshy part of the side of the hand between the wrist and the little finger knuckle while talking. If they do, then as practitioner you do, too.

This seems to help people to tell their stories. It may help to reduce anxiety about doing so and may even clear some of the emotions that come up as they talk. For the therapist, it helps minimize the risk of secondary traumatization when we are hearing of horrendous experiences.

I am talking here about this side of the hand tapping when telling a therapist what has happened in the week since their last session or what happened back then. I am not talking about the story-telling technique described earlier.

Whether and when it is a good time to introduce side of the hand tapping with a client is a matter of clinical judgement. In general, it is likely to be sooner with someone who already knows tapping because then you do not have to interrupt their flow to explain what it is and how and why to do it.

Sometimes if clients are finding it hard to say anything, it can help them to get started. But with some clients, you can just say "imitate me" and let them continue to talk.

Rapport building can also be enhanced by mirroring a client's posture and delivery. Mirroring means that when a client moves you make a similar move, delayed and modified enough for the client to pick it up unconsciously. You do not want them to think consciously that you are imitating them.

If you have an NLP background you may use NLP rapport building techniques automatically. If you do not, you may feel this is too artificial an approach and find that if you are really tuned in to a client you will unconsciously do this anyway.

I find it is sometimes helpful way to check as opposed to using it to establish rapport. When I am deciding if it is time to steer a session to something more difficult, I sometimes use "reverse" rapport. It means making a move and seeing if the client follows. So, you might cross your legs or ankles or uncross them, for example. If your client does the same or similar soon after, your rapport is good.

THE ABSOLUTE KEY REQUIREMENT FOR RAPPORT WITH TRAUMA CLIENTS IS SAFETY.

Safety is always key for clients. For trauma clients this is even more essential.

This means:

- Giving control to clients. That starts right at the beginning with how far from you they want to sit. And at what angle. Do they want to be at an angle or directly opposite you? Being at an angle can seem less confronting but let your client decide. (It is a good idea not to have a client where they are blocking your route to the door, just in case...)
- Later when you are doing EFT interventions or other therapeutic work with them safety will mean agreeing to stop whenever they want, and even to have a pre-agreed stop signal so they have more options.

I tap with clients rather than on them most of the time. In time of high emotion, I will change, with permission, to tapping on.

If you are going to do this, you need to ask for permission to tap on, then for permission to move closer. And do not just accept a verbal "yes." Watch that their body language is congruent with the spoken consent.

Stephen Porges, whose polyvagal theory we covered earlier, has also made a major contribution to how we need to build a relationship with a client from the very earlier stages of trauma therapy. He says:

THE ABSOLUTE KEY REQUIRMENT FOR RAPPORT WITH TRAUMA CLIENTS IS AN **UNCONSCIOUS** PERCEPTION OF SAFETY.

Porges' word for this is Neuroception – the unconscious equivalent of the conscious perception. In fact, he discourages the use of the word perception at all because that implies some kind of recognition which is absent from Neuroception. It happens below the radar.

Porges uses the term "feature detectors" for the elements that Neuroception uses to determine what a safe social situation is.

Neuroception detects safety via the ventral vagal social engagement system for which the right cues include acoustic, one of the most potent ways to signal safety. If you think about babies and the way mothers usually speak to them, and the lullabies they sing, notice that they are not using low frequencies. Low frequencies signal danger.

Porges uses Peter and the Wolf as a nice example. Prokofiev, with intuitive understanding of this used violin, clarinet, flute and oboe for non-threatening

characters and lower frequency sounds for the baddies.

Besides pitch, one of the most important elements of this social engagement rapport is voice intonation. Porges calls it prosody. He says our nervous system is automatically detecting the prosodic features (speech variables including rhythm, speed, pitch, and relative emphasis) that distinguish vocal patterns.

We can close our eyes when we don't want to look at something. But we cannot close our ears. What they hear is particularly important for people with trauma histories. They often have difficulty making eye contact, but they cannot turn off their nervous system's ability to interpret the prosodic features of voice. That ability is hardwired. There is no safe social engagement unless our system picks up the right signals.

So, we need to use a melodic voice which avoids too low a pitch.

The ventral (front) vagal nerve controls the muscles of the face, as well as the heart and lungs — the parts of the body used to interact with others. This mammalian species-specific system is thus enabling of what Porges calls "social engagement."

Polyvagal theory also says that the vagal circuits are hierarchical. That means that when we are able to connect with the newest social engagement system in therapy, not only may it give people the feeling that they are safe with us but it will also be able to help inhibit or dampen the older fight/flight response. Which means that it will help to inhibit automatic triggering of feelings of being under threat as they start to think about trauma memories.

Its contribution to building rapport is that it goes way beyond a cognitive understanding that our therapy room is a safe place. It helps client realize at a level beyond conscious awareness that they are in safe surroundings. And when our nervous system detects a sufficient level of safety, our physiology responds.

This is key because without this physiological rapport, clients may leave feeling that they we said all the right things but there was something about us that was somehow unconvincing. And these may well be clients who take a lot of convincing that any help is possible in the first place. For our clients' s sake, we need to stack all we can on our side.

Another element of social engagement is that it is the upper part of the face that gives cues to safety. A fake smile emphasises the lower part of the face. We intuitively talk about people smiling with their mouths but not their eyes. Smile wrinkles around the eyes are a positive asset. Therapists are advised not

to be tempted to Botox them away.

For a person with trauma history, gestures may be misinterpreted. Voice prosody will not.

MORE RAPPORT

Another level at which I think it is essential to establish rapport with all clients, trauma and other, is intellectually. It is not on its own sufficient. But for some it is an essential pre-requisite.

That means being able to explain trauma and EFT at an appropriate level for each client.

For some people just telling them that EFT is like a psychological version of acupuncture is enough. Others will want to know more. They may want to know current thinking about how it works. They may want to know what the research evidence is.

The same is true of trauma. Attention has already been paid to psychoeducation and neuro-education about what trauma is and its inevitable effects on us. But some clients will want more specifically about EFT and how tapping on points on the body can make a difference.

They may want to know a) what outcome studies have shown and b) by what mechanisms EFT is thought to undo the effects of trauma.

It is useful to have a resource library to make available to those clients who want to know about the research into EFT in general and EFT and trauma in particular.

For example, one study of PTSD in American service veterans found EFT to work twice as well to reduce their symptoms as the more traditional exposure therapy in half the time. In other words, you could say EFT worked four times as well.

Other studies have found that after tapping stress hormones were reduced, immunity genes upregulated and inflammatory genes downrated. Inflammation is the root of all physical evils including cancer. A tumour is inflammation. Uprating immunity means, for example, that someone exposed to germs from a sneeze at close quarters can have the risk that they will get the cold reduced to a fifth of that of someone will a less active immune system.

Energy psychology, which includes but is not exclusively EFT, has a large and growing number of random controlled studies. There is a detailed account of research on the website www.eftinternational.org

There more than 400 therapies in the world. Most have no research. The findings put energy psychology in the top ten percent of all therapies in terms of research on effectiveness.

It is one of the brilliant things about EFT that linked memories often pop up when we are working with a traumatic memory. Sometimes it is a previously unconscious implicit memory. Often it is a conscious explicit memory that the person remembered but had not connected with the feeling or issue we are dealing with.

It amazes me how often, especially when you finish a round of tapping and ask them "What came up" or "what is coming up" people will say something like: "I do not know why I am thinking about this. It cannot be connected. I think my mind has just wandered…"

Nevertheless, when we are working with trauma we do not want to rely just on automatic pop-ups.

We know that memories are not stored in nodes that are left-brained logical. The way they are connected is more subtle. But one way to help clients find a way back to an earlier linked experience, if they do not show themselves automatically, is to ask them to really focus on an emotion or a body feeling and let their minds drift back to an earlier time they had the same experience.

When they do find something linked, I like to ask them to take a little time to see if there is something even earlier. We are looking for the earliest.

It can also be helpful at times, when we are looking for antecedents, to ask a client about the negative belief about themselves that is related to a specific negative memory and then to ask about any other memory they have that has the same belief.

Generally, when we process a memory the linked belief evaporates with it. But it does not always happen so neatly. It is helpful to remember to think about beliefs as well as emotions and that we can tap on memories using the VOC (validity of cognition) scale – how true does that FEEL.

At the start of our work it is good practice to get a client's trauma history. That is not always as easy or as uncomplicated as it sounds.

We do not want to pin people down and grill them. Much of it will come up anyway when they tell their stories. Some things they will not be willing to reveal until they know us better, no matter how textbook our rapport-building is. Some they will not even realize are relevant in the beginning.

It is our job to listen, not theirs to save us from having to.

And it is our job to watch for the unspoken remnants of traumas that can often be processed without going into the narrative at all.

As Bessel Van der Kolk says: “The imprint of trauma doesn’t sit in the verbal, understanding part of the brain, but in much deeper regions – amygdala, hippocampus, hypothalamus, brain stem – which are only marginally affected by thinking and cognition.

“… to do effective therapy we need to do things that change the way people regulate these core functions, which probably cannot be done by words and language alone.”

Some people will come into therapy because they want to deal with a trauma or traumas that they know to be still affecting them. Others, the roots of whose difficulties are unrecognized trauma, will have no idea where they will need to go.

As I have said, finding those connections by consciously looking for them is usually not a productive exercise anyway when they tend to be stored in groups not connected by such conscious logic as content or relationship or time frame.

We can gradually compile a trauma history by flagging up for ourselves whatever traumas come up in the initial session or sessions and adding them to the list along the way.

It may not be necessary to process each one. Experience shows that there may be a generalization effect once we deal with a representative sample. But the more we know the more likely we are to pick up cues and clues as we work.

AFTER RAPPORT, RESOURCES

Before we move into the EFT treatment phase of therapy, it is important to work with clients to establish resources.

Some of the more recent research on therapy outcome has suggested that being able to provide clients with relevant resources may be almost as important a predictor of outcome as rapport.

People come with resources, even if they need more and different ones to work through this stage of therapy. We should never forget that defences are resources. It is not our job to remove them. It is our job to help people find choices, to work towards no longer needing a defence.

A client without the ability to self-regulate and self-soothe is most vulnerable to be triggered and potentially retraumatized both in everyday life outside

therapy and when we start to process specific memories.

- Tapping, is, of course, a brilliant resource for people to have. A client who can use it to deal with feelings that come up outside the therapy room is in a much better place to work safely than one who cannot.

However, there is always a risk that if they start tapping on their own, they may access more than they or you intended.

It may be wise to recommend to trauma clients that they do not try to analyse or link or delve into why feelings are coming up on their own outside sessions, at least in the early stages of therapy. It is safer if they just tap on the actual feelings until they feel rebalanced enough to carry on normal life. I also ask that they make notes of any insights or memories that come up to bring to the next session.

Of course, there is never any guarantee that they will not trigger more than they intend.

Breathing is also key. Teach clients ways to breathe when they feel anxious. Basically, techniques that make the out breath longer than the in breath are calming. So, encourage them to practice breathing in for a count of three out for five, or five and seven. Or any other breathing technique you know and use.

- Singing or playing a wind instrument are also good way to calm the system, for those for whom these options are relevant and appealing.
- Playing and dancing are good. So is yoga.
- Friends. The better the support network a person has the better their recovery from post-traumatic stress. Unfortunately, people whose early experiences led them to be wary of social relationships are statistically the very people most likely to suffer post-traumatic stress after negative experiences. And people who are traumatized tend to withdraw from the very social circles that could support their recovery. However encouraging them to reconnect with people as much as they can, and to seek, accept and value any potential sources of social support, can be helpful.
- Joining a choir or a yoga class may offer not only a de-stressing activity but also a potential source of supportive contact. And yoga can easily be adapted to being a mindful activity (see below). Good yoga teachers put a lot of emphasis on noticing what is going on in the body. Some are even training to use yoga in specifically therapeutic ways.

MINDFULNESS AS A RESOURCE

Another potentially valuable help for trauma clients is to have some kind of mindfulness practice. However, THIS NEEDS TO BE DONE WITH EXTREME CAUTION.

Mindfulness is the ability to be present in the moment. It has been defined by Jon Kabat-Zinn, pioneer of the use of mindfulness for stress reduction in the West, as "paying attention in a particular way, on purpose, to the present moment and without judgment."

The ability to exercise mindfulness is cultivated by mindfulness practices, especially mindfulness meditation practices.

With traumatized clients, it is wise to be cautious. It is a matter of sensitive clinical judgment when a client is ready to bring any kind of Mindfulness into the recovery programme. For some people who have been traumatized, mindful meditation can terrify prospect.

The last thing they feel will support their recovery is to go into what they perceive as the deep black void inside.

I have had one client for whom even ten seconds of going inside and focussing on her breathing on her own was so frightening she would not even contemplate it. With me in the room with her, she could just about tolerate about 30 seconds but no more than that. On her own, she could not even think about it. She became really anxious just talking about it.

If you know or suspect that someone has a lot of split off trauma memories, they are probably not ready for mindful meditation. What is more relevant for them is grounding.

So, feeling their feet on the floor, or the chair they are sitting on, might be more helpful. Or squeezing their own leg. Often people prefer to find their own version or tell you the one they already have. These are also useful ways to help bring someone out of a dissociated state and back into the room.

Asking people to find what they feel is a safe space in their bodies means that when they start to take their attention to a specific trauma very briefly to start with, they can keep taking their attention back to the safe space.

When they are ready to move to the next stage, less challenging places than meditation to start are practices like walking mindfully or doing yoga mindfully. And from that they may go on to a meditation that involves focussing not on themselves but on something external – like the sounds that they can hear around them.

When they are ready, combining such a practice with noticing when their

thoughts stray from the task and taking them back to it can also help build confidence in being able to have some mental control.

Loving kindness and compassion practices, too, may be better suited to many trauma clients than meditation without an agenda beyond noticing what comes up.

If you do not have experience of using mindfulness with therapy clients, I would recommend that you read Mindfulness and Psychotherapy edited by Germer, Siegal and Fulton as well as doing your own mindfulness practice before you consider bringing it into trauma work.

Even better train in using mindfulness in therapy if you are planning to use it with clients. Some courses are better than others. If you cannot get a recommendation for a local one, consider online training. My own experience has been that I have found better mindfulness courses online than in the real world.

Many mindful practices start by focussing on the breath. Just that alone can be helpful for some clients when they are ready for it. It can be combined with teaching breathing techniques as above.

COMPASSION

Whether by mindfulness compassion practices or not, cultivating compassion for self is a key component of good trauma therapy.

I like to talk to clients about compassion and to discuss with them how they can show themselves more compassion in their lives. It can be less challenging to start with this broader consideration before you ask them to start to apply it to their trauma experiences.

What could they do in their everyday lives to be nicer to themselves? There are going to be as many answers as there are clients.

Besides what they come up with for themselves a short compassion exercise I also like to show people and to ask them to do as homework is a version of the butterfly hug. I think of all the homework practices I have asked people to do over the years this has probably had the best take-up and the best feedback.

The name comes from an EMDR practice used with children.

The idea is for a person to cross their arms so they are holding the opposite upper arm with each hand, roughly midway between elbow and shoulder, and to tap their arms with their hands alternately.

This was devised originally by EMDR therapists on a humanitarian mission to

a refugee camp where they had a large number of traumatized children and a small number of therapists.

What they did was to have the children draw pictures of the home they had left. Then they looked at the pictures while giving themselves bilateral stimulation by tapping alternate arms as described above.

They would then draw a new picture. Comparing old and new gave therapists feedback about their progress. Most were processing their traumas for themselves. The ones who were not showing change were then given priority for the scarce one-to-one attention.

In my pre-EFT days, when I used EMDR with children, I taught a number to do this and often they told me it had been really helpful as in-the-moment first aid when they were upset.

My current EFT based variation of this is to say, while doing the alternative arms tapping: “I accept myself without judgment” or “I accept myself with compassion” or whatever seems most relevant to where a client is in therapy and/or which most appeals to them.

The EFT butterfly hug is combines tapping with the fingertips, which have meridian relevance, bilateral stimulation by the hand, self-acceptance and a focus on being kinder to ourselves.

BRAKES FIRST

It is always important in trauma work to ensure you have good working brakes before you hit the accelerator.

Teaching people to tap, breathing techniques, doing things like yoga or singing in a choir, all help to have some braking system.

Within therapy, I like not only to encourage people to identify and use a safe place in their bodies, as outlined above, but also to identify or create a safe place to go in their minds.

There is a case for having them invent a safe place rather than use a place they know or have known. An invented and present tense safe place is unlikely to have any associations with traumatic experiences.

There is a kind of uber safe place visualization which I like to use with some clients before we do trauma work. It is a composite co-devised by a number of therapists over the years. It involves imagining being in a place with a see-through dome above and the same sort of dome below so that they are in a completely sealed environment. No one can enter without invitation.

Then, within the dome they can choose what sort of landscape it is. Field, meadow, wood, beach etc. It needs to be somewhere they invent and where they feel really safe.

I like to invite them to have in it a single storey dwelling of some kind, but without basement or attic. They design it. They decorate it. But within it, or somewhere within the dome, they are invited to set up a kind of night safe – a place where they can deposit, but no one but them can withdraw and then only at a time of their choosing

In it they can put the metaphorical DVDs of memories they want to process at some time but where they can stay safely and away from current access until they are ready to work on them.

They are also invited to put a pool or a waterfall somewhere within the dome.

Some clients like to do this visualization for themselves between sessions.

One caution here: it is a fine line between visualisation and hypnosis. Most people will go into trance doing whichever you call it. This is particularly going to be true for those of you who have hypnosis training and probably automatically drop into a hypnotic voice.

For those of you less familiar with hypnotic states, people go in and out of trance all the time, but probably even more in therapy than elsewhere.

It may be, as people who study hypnosis claim, that high stress situations such as those that cause trauma, put people automatically into a trance state. Trauma has been described as a psych neurophysiological dissociation

One of my favourite hypnosis teachers way back was Dr Brian Roet who used to say his favourite hypnotic induction was: “Close your eyes and go inside.”

HYPNOSIS WARNING

For those of you who have hypnosis in your toolkit, I strongly advise against using hypnotic techniques to deal with specific traumatic memories.

I know a lot of people who do not know much about it are prejudiced against hypnosis. So, let me say I am not one of them. One of my early trainings was in hypnotherapy. I studied it extensively. I devised a course and taught a course in clinical hypnosis which was approved by the leading UK hypnotherapy body. I am not anti-hypnotherapy per se.

I know that in both hypnosis and NLP there are accepted techniques (screen, rewind etc) to this. But my concern about them is that they depend on dissociating people from the memory so that they are looking at it, not in it.

This would be good if you could guarantee that you could, and they could. No matter how good a client is at doing this, or how good you are at using hypnosis, there is no guarantee people will manage to stay dissociated.

And if a client does go into a "raw" unprocessed trauma memory they are likely to experience it even more vividly than they would in a non-hypnotic state. Hypnosis tends to turn up the volume on sensory and emotional information.

THE TRAUMA TREATMENT PHASE

As I have said it makes sense to start with awareness of body sensations and how to work with them before we go anywhere near specific memories.

When we are ready to process individual memories, we can sneak up. Ask a client how they feel about approaching the memories. Tap on any reluctance, anxiety, fear, or any other negative emotion or body sensation they identify before you go ahead.

The movie technique, tearless trauma and story-telling have been described earlier.

MORE TIPS FOR THE MOVIE TECHNIQUE

- Remember the distancing suggestions. You can put the DVD in another room – or on another planet.
- You do not have to get the SUDS to zero by the end of a session. I think keeping strict time boundaries helps client feel safer with us. If they are not zero, just check at the start of the next session. Once they start processing, they often keep going down by themselves.
- Don't start processing a trauma when you do not have a lot of time left in the session It a) risks a client not being in a good state to leave at the end of the session and b) violating a client's assumption that they are safe to bring up something towards the end of a session because that means they will not have to psych themselves up to do so next time. Clients often trust, if they know you are keeping strict time boundaries, that you will not start working on it until next time.
- When people think a memory is zero, test, test, test. Story-telling, as outlined earlier, is a way both to finish and test processing. Sometimes it brings up aspects that people unintentionally excluded completely from their movie.
- Then ask them to bring up the original memory and note changes. If it is less visually vivid, has a quieter sound track and/or seems longer ago or

further away that confirms that there has been some successful processing.

- If someone says they were in the original movie and are now outside watching it that dissociation is a good sign, too.
- To test that it is a really robust result, ask them to try to get the movie back to the way it was. Can they restore the colour? The soundtrack, move it back closer, make it more recent? If they can and the emotion comes back up, too, you are not yet done.

Of course, the real test is always what happens outside the therapy room. If it even better if a person reports that they feel different, that they experienced something that would usually be a problem for them, and it did not trigger a response.

When you are asking for a 1 to 10 SUDS measure on anything, whether it is a trauma memory of an anxiety response, and people say they cannot "do" SUDS in the conventional way just ask them to guess. Guessing accesses what we know unconsciously but do not consciously know that we know. It is surprisingly reliable. And it is a multi-use tool, not just for SUDS.

If you are working with a child, you can have them indicate intensity with their hands. Wide apart is 10. Barely apart might be a one or two. But once they reach the stage where they can do it in numbers, in my experience most love to do it that way.

SURROGATE TAPPING

Besides the use of the movie technique with an invented movie for experiences stored early in implicit memory outlined earlier, another option is to tap on the younger self.

The way I like to tap surrogately is to imagine I am the subject of the tapping. So, say you wanted to tap on a "memory" of being taken away from your mother and put in an incubator immediately after birth. It is not difficult to imagine/ guess how that deprivation of familiar environment, skin touch, voice and so on would feel.

There is also a good case for doing similar surrogate tapping for a self who was caught up in an event for which you have post traumatic amnesia. In this case instead of using the set-up "Even though I am … and inserting the name of the person you are tapping for, you would use something like "Even though I am my seven-year-old self… or "Even though I am seven and I am trapped in this water pipe and… and then switch to set-ups like: "Even though I feel so scared… "Even though I think I am going to die… and "Even though I cannot

breathe…

GENETIC INTERGENERATIONAL TRAUMA

There is growing evidence that trauma is transmitted through generations. What we are carrying may not actually have happened to us at all. But it may have marked us, nevertheless.

In a study published in December 2013 experimenters taught mice to link the smell of cherry blossoms with pain. Their off-spring, with no previous experience of cherry blossom, showed fear when they were first exposed to it.

More recent work has shown the mechanism to be via RNA in sperm. And that the effects carried on to a third generation.

This comes as less of a surprise in the light of studies such as the one by a research team at New York's Mount Sinai hospital showing genetic changes stemming from the trauma suffered by Holocaust survivors are capable of being passed on to their children.

The study of 32 Jewish men and women who had been interned in a Nazi concentration camp or had witnessed or experienced torture or had had to hide during World War 2 found that their children had increased likelihood of stress disorders compared with Jewish families living outside Europe during the war.

They found epigenetic tags on the very same part of a gene associated with the regulation of stress hormones in both the Holocaust survivors and their offspring. The same correlation was not found in any of the control group and their children.

After controlling for other variables, the team concluded "The gene changes in the children could only be attributed to Holocaust exposure in the parents"

The focus of this research was specifically on finding the relevant genetic mechanism of transmission. But Bruce Lipton's work reminds us that our DNA is only a blueprint. Which genes are expressed is dependant largely on their environment? Change the environment, including the emotional environment – for example by tapping – and you change the likelihood that that gene will be expressed.

But there is no reason we cannot surrogate tap for ancestors and for the part of ourselves that carries their traumas and for the infant self born with this genetic possibility.

When we tap on any negative or unwanted body feeling it makes no difference

whether it comes from our own lives or from ancestral ones or past lives.

OTHER TRAUMA RESOURCES

Here are some additional resources to use with EFT in working with trauma.

CHOICES

Patricia Carrington's choices method is a useful tool to have in your trauma kit. (see www.Patcarrington.com).

In choices, the set up becomes: "Even though I have this … I choose to that…" The protocol is also slightly different. It is worth downloading Pat's manual from her website and familiarizing yourself with it.

Obviously in most situation if we could choose something different, we would. But by making choices like: "I choose to discover how to..." or something similar, then we challenge our unconscious minds to find a way.

Choices can usefully be pressed into service when we are helping clients to rebuild a new life and a new sense of self after we have used EFT to clear trauma.

Different explanations have been put forward for why something as seemingly simple as the movie technique can make the difference it often does in a traumatic memory.

We know that every time we remember something, we edit it in some way to make more sense of it from where we are now. What we return to our memory store is never what we retrieved. So, pairing the memory with tapping, which produces some physical relaxation of the body, with the memory useful.

We have evidence from random controlled trials that tapping on trauma reduces the level of such stress hormones as cortisol and adrenalin in the body.

This both produces the less aroused state which becomes paired with the memory and has wider implications over the whole 24 hours for people who have experienced trauma.

People with post traumatic stress have maladaptive cortisol levels not just when something triggers the trauma but throughout the day. They have messed up sleep patterns. They wake which in turn messes up cortisol levels.

MODULE 4

The first requirement for working with trauma is the same as it is for working with a client with any issue – RAPPORT. But with trauma clients it is an even

more crucial and tricky relationship to establish and maintain.

The finding from a meta-analysis by John Norcross of all therapy outcome studies is that the best predictor of a positive outcome is what he called PRESENCE which he defined as the ability to be empathetic to our internal world, actively seek feedback, and being open to it rather than defensive.

To me that says “and don’t rush in.” Don’t start with immediate machine gun salvo of tapping. New therapists often feel the urge to. It takes time to appreciate the value of listening deeply. It is not, as newbies often feel, doing nothing.

As you give clients time and space to tell their stories, and that means the stories of them, not just the stories of their traumas, you are listening at multiple levels. You are listening with your left brain, for the cognitive content. You are ordering it especially by listening for mentions or hints of past trauma events of situations and relationships to note in the client’s trauma history.

You are listening with your right brain for things they may not be aware they are telling you. The unconscious mind will often reveal the information they are not consciously disclosing, and may not even be consciously aware of, in metaphors. Listen for them. And note down words or phrases that strike you as interesting or out of character or just somehow catch your ear.

Even if they do not make sense at the time, it is fascinating how often down the line you will realize they are somehow key. In fact, if you feel therapy is stuck and do not know why or what you are missing it is always worth going back to the first session to see if there was a clue there the significance of which you did not get at the time.

Listen for what clients are not saying.

And listen for changes of breathing or intonation as clients tell you their story.

Use your eyes. Is there any revealing body language also giving you information from their unconscious mind? It might be no more subtle than telling you how they are really up for change while they are while literally digging their heels into your carpet. But it might not.

I have seen clients doing that. You probably have, too.

When you are going to be working explicitly with trauma, and even if you do not know you are, watch particularly for anything that might be a truncated trauma response. If someone wanted to run but could not, you might pick up minute movements in their feet. Or if they wanted to punch and did not dare, ditto fist. Or if there is a slight movement towards looking over a shoulder as

they tell of a traumatic attack, note that too.

They are cues you need to return to. Down the line you will want to decide together how to work with them. They could be clues that unlock aspects of trauma memories not otherwise available to conscious recollection. They may be tappable – "Even though I did not run…." or "Even though I could not run…" for example.

Or if you notice they almost start to look over one shoulder you might want to explore this later by asking the client something like: "Just look over your shoulder and see what happens when you do."

Whether it is a memory or a feeling, it could be a useful tapping focus.

Use your own gut. Notice what happens in your gut as you and the client attune. This it is not about you. But it is about what you pick up unconsciously about your client. It is where empathy is most likely to be experienced.

Hopefully you have done and keep doing your personal peace plan - working systematically through your own negative memories - to keep the potential intrusion of your own stuff to a minimum. And hopefully you have a technique to park it until after the session if something does come up for you.

I don't know if it is just superstition or a testable truth (as far as I know not systematically tested) but most of us have had the experience of seeming to attract what we ourselves need to work on. When this happens, we are even more likely to be triggered by things our clients tell us.

This means we might be tempted to think we understand what they are telling us because we have experienced it, too. We have not. We have experienced what we have experienced. We can only know what clients have by asking them and listening to them.

Your role here is empathy, not sympathy. You want to get as far as you can into the world of the client. That is your shared workplace. And one of the ways to maximise our ability to have empathy is mindfulness meditation which can also hone our ability for deep attention. The more you are aware of your own bodily sensations the more you can tune in to other people's emotional states.

Studies at UCLA and Harvard show there are actual structural changes in the brains of people who practice mindfulness meditation and they are in those parts of the brain we need to support empathy with other people. The neural circuits we are strengthening are the same circuits we need using to tune in to the internal world of someone else.

Although I said earlier don't rush into tapping, I think the exception to that is

tapping on the side of the hand (what we used to call the karate chop) in which a client just taps on the fleshy part of the side of the hand between the wrist and the little finger knuckle while talking. If they do, then as therapist you do, too.

This seems to help people to tell their stories. It may help to reduce anxiety about doing so and may even clear some of the emotions that come up as they talk. For the therapist, it helps minimize the risk of secondary traumatization when we are hearing of horrendous experiences.

I am talking here about this side of the hand tapping when telling a therapist what has happened in the week since their last session or what happened back then. I am not talking about the story-telling technique described earlier.

Whether and when it is a good time to introduce side of the hand tapping with a client is a matter of clinical judgement. In general, it is likely to be sooner with someone who already knows tapping because then you do not have to interrupt their flow to explain what it is and how and why to do it.

Sometimes if clients are finding it hard to say anything, it can help them to get started. But with some clients, you can just say “imitate me” and let them continue to talk.

Rapport building can also be enhanced by mirroring a client’s posture and delivery. Mirroring means that when a client moves you make a similar move, delayed and modified enough for the client to pick it up unconsciously. You do not want them to think consciously that you are imitating them.

If you have an NLP background you may use NLP rapport building techniques automatically. If you do not, you may feel this is too artificial an approach and find that if you are really tuned in to a client you will unconsciously do this anyway.

I find it is sometimes helpful way to check as opposed to using it to establish rapport. When I am deciding if it is time to steer a session to something more difficult, I sometimes use “reverse” rapport. It means making a move and seeing if the client follows. So, you might cross your legs or ankles or uncross them, for example. If your client does the same or similar soon after, your rapport is good.

THE ABSOLUTE KEY REQUIREMENT FOR RAPPORT WITH TRAUMA CLIENTS IS SAFETY.

Safety is always key for clients. For trauma clients this is even more essential.

This means:

- Giving control to clients. That starts right at the beginning with how far from you they want to sit. And at what angle. Do they want to be at an angle or directly opposite you? Being at an angle can seem less confronting but let your client decide. (It is a good idea not to have a client where they are blocking your route to the door, just in case...)
- Later when you are doing EFT interventions or other therapeutic work with them safety will mean agreeing to stop whenever they want, and even to have a pre-agreed stop signal so they have more options.

I tap with clients rather than on them most of the time. In time of high emotion, I will change, with permission, to tapping on.

If you are going to do this, you need to ask for permission to tap on, then for permission to move closer. And do not just accept a verbal "yes." Watch that their body language is congruent with the spoken consent.

Stephen Porges, whose polyvagal theory we covered earlier, has also made a major contribution to how we need to build a relationship with a client from the very earlier stages of trauma therapy. He says:

THE ABSOLUTE KEY REQUIRMENT FOR RAPPORT WITH TRAUMA CLIENTS IS AN **UNCONSCIOUS** PERCEPTION OF SAFETY

Porges' word for this is Neuroception – the unconscious equivalent of the conscious perception. In fact, he discourages the use of the word perception at all because that implies some kind of recognition which is absent from Neuroception. It happens below the radar.

Porges uses the term "feature detectors" for the elements that Neuroception uses to determine what a safe social situation is.

Neuroception detects safety via the ventral vagal social engagement system for which the right cues include acoustic, one of the most potent ways to signal safety. If you think about babies and the way mothers usually speak to them, and the lullabies they sing, notice that they are not using low frequencies. Low frequencies signal danger.

Porges uses Peter and the Wolf as a nice example. Prokofiev, with intuitive understanding of this used violin, clarinet, flute and oboe for non-threatening characters and lower frequency sounds for the baddies.

Besides pitch, one of the most important elements of this social engagement rapport is voice intonation. Porges calls it prosody. He says our nervous system is automatically detecting the prosodic features (speech variables including rhythm, speed, pitch, and relative emphasis) that distinguish vocal

patterns.

We can close our eyes when we don't want to look at something. But we cannot close our ears. What they hear is particularly important for people with trauma histories. They often have difficulty making eye contact, but they cannot turn off their nervous system's ability to interpret the prosodic features of voice. That ability is hardwired. There is no safe social engagement unless our system picks up the right signals.

So, we need to use a melodic voice which avoids too low a pitch.

The ventral (front) vagal nerve controls the muscles of the face, as well as the heart and lungs — the parts of the body used to interact with others. This mammalian species specific system is thus enabling of what Porges calls "social engagement."

Polyvagal theory also says that the vagal circuits are hierarchical. That means that when we are able to connect with the newest social engagement system in therapy, not only may it give people the feeling that they are safe with us but it will also be able to help inhibit or dampen the older fight/flight response. Which means that it will help to inhibit automatic triggering of feelings of being under threat as they start to think about trauma memories.

Its contribution to building rapport is that it goes way beyond a cognitive understanding that our therapy room is a safe place. It helps client realize at a level beyond conscious awareness that they are in safe surroundings. And when our nervous system detects a sufficient level of safety, our physiology responds.

This is key because without this physiological rapport, clients may leave feeling that they we said all the right things but there was something about us that was somehow unconvincing. And these may well be clients who take a lot of convincing that any help is possible in the first place. For our clients' s sake, we need to stack all we can on our side.

Another element of social engagement is that it is the upper part of the face that gives cues to safety. A fake smile emphasises the lower part of the face. We intuitively talk about people smiling with their mouths but not their eyes. Smile wrinkles around the eyes are a positive asset. Therapists are advised not to be tempted to Botox them away.

For a person with trauma history, gestures may be misinterpreted. Voice prosody will not.

MORE RAPPORT

Another level at which I think it is essential to establish rapport with all clients, trauma and other, is intellectually. It is not on its own sufficient. But for some it is an essential pre-requisite.

That means being able to explain trauma and EFT at an appropriate level for each client.

For some people just telling them that EFT is like a psychological version of acupuncture is enough. Others will want to know more. They may want to know current thinking about how it works. They may want to know what the research evidence is.

The same is true of trauma. Attention has already been paid to psychoeducation and neuro-education about what trauma is and its inevitable effects on us. But some clients will want more specifically about EFT and how tapping on points on the body can make a difference.

They may want to know a) what outcome studies have shown and b) by what mechanisms EFT is thought to undo the effects of trauma.

It is useful to have a resource library to make available to those clients who want to know about the research into EFT in general and EFT and trauma in particular.

For example, one study of PTSD in American service veterans found EFT to work twice as well to reduce their symptoms as the more traditional exposure therapy in half the time. In other words, you could say EFT worked four times as well.

Other studies have found that after tapping stress hormones were reduced, immunity genes upregulated and inflammatory genes downrated. Inflammation is the root of all physical evils including cancer. A tumour is inflammation. Uprating immunity means, for example, that someone exposed to germs from a sneeze at close quarters can have the risk that they will get the cold reduced to a fifth of that of someone will a less active immune system.

Energy psychology, which includes but is not exclusively EFT, has more than 60 published studies in peer reviewed journals, 20 of them random controlled trials, with more than 98% of findings supporting the efficacy of energy psychology. Of the studies looking at follow-up from three months to two years, 100% found that the gains held. There is even a meta-analysis showing medium effect sizes.

There more than 400 therapies in the world. Most have no research. These findings put energy psychology in the top ten percent of all therapies in terms

of research on effectiveness,

There is a detailed account of research on the website www.eftinternational.org

It is one of the brilliant things about EFT that linked memories often pop up when we are working with a traumatic memory. Sometimes it is a previously unconscious implicit memory. Often it is a conscious explicit memory that the person remembered but had not connected with the feeling or issue we are dealing with.

It amazes me how often, especially when you finish a round of tapping and ask them "What came up" or "what is coming up" people will say something like: "I do not know why I am thinking about this. It cannot be connected. I think my mind has just wandered…"

When we are working with trauma we do not want to rely just on automatic pop-ups.

We know that memories are not stored in nodes that are left-brained logical. The way they are connected is more subtle. But one way to help clients find a way back to an earlier linked experience, if they do not show themselves automatically, is to ask them to really focus on an emotion or a body feeling and let their minds drift back to an earlier time they had the same experience.

When they do find something linked, I like to ask them to take a little time to see if there is something even earlier. We are looking for the earliest.

It can also be helpful at times, when we are looking for antecedents, to ask a client about the negative belief about themselves that is related to a specific negative memory and then to ask about any other memory they have that has the same belief.

Generally, when we process a memory the linked belief evaporates with it. But it does not always happen so neatly. It is helpful to remember to think about beliefs as well as emotions and that we can tap on memories using the VOC (validity of cognition) scale – how true does that FEEL.

At the start of trauma, it is good practice to get a client's trauma history. That is not always as easy or as uncomplicated as it sounds.

We do not want to pin people down and grill them. Much of it will come up anyway when they tell their stories. Some things they will not be willing to reveal until they know us better, no matter how textbook our rapport-building is. Some they will not even realize are relevant in the beginning.

It is our job to listen, not theirs to save us from having to.

And it is our job to watch for the unspoken remnants of traumas that can often be processed without going into the narrative at all.

As Bessel Van der Kolk says: “The imprint of trauma doesn’t sit in the verbal, understanding part of the brain, but in much deeper regions – amygdala, hippocampus, hypothalamus, brain stem – which are only marginally affected by thinking and cognition.

“… to do effective therapy we need to do things that change the way people regulate these core functions, which probably cannot be done by words and language alone.”

Some people will come into therapy because they want to deal with a trauma or traumas that they know to be still affecting them. Others, the roots of whose difficulties are unrecognized trauma, will have no idea where they will need to go.

As I have said, finding those connections by consciously looking for them is usually not a productive exercise anyway when they tend to be stored in groups not connected by such conscious logic as content or relationship or time frame.

We can gradually compile a trauma history by flagging up for ourselves whatever traumas come up in the initial session or sessions and adding them to the list along the way.

It may not be necessary to process each one. Experience shows that there may be a generalization effect once we deal with a representative sample. But the more we know the more likely we are to pick up cues and clues as we work.

AFTER RAPPORT, RESOURCES

Before we move into the EFT treatment phase of therapy, it is important to work with clients to establish resources.

Some of the more recent research on therapy outcome has suggested that being able to provide clients with relevant resources may be almost as important a predictor of outcome as rapport.

People come with resources, even if they need more and different ones to work through this stage of therapy. We should never forget that defences are resources. It is not our job to remove them. It is our job to help people find choices, to work towards no longer needing a defence.

A client without the ability to self-regulate and self-soothe is most vulnerable

to be triggered and potentially retraumatized both in everyday life outside therapy and when we start to process specific memories.

- Tapping, is, of course, a brilliant resource for people to have. A client who can use it to deal with feelings that come up outside the therapy room is in a much better place to work safely than one who cannot.

However, there is always a risk that if they start tapping on their own, they may access more than they or you intended.

It may be wise to recommend to trauma clients that they do not try to analyse or link or delve into why feelings are coming up on their own outside sessions, at least in the early stages of therapy. It is safer if they just tap on the actual feelings until they feel rebalanced enough to carry on normal life. I also ask that they make notes of any insights or memories that come up to bring to the next session.

Of course, there is never any guarantee that they will not trigger more than they intend.

- Breathing is also key. Teach clients ways to breathe when they feel anxious. Basically, techniques that make the out breath longer than the in breath are calming. So, encourage them to practice breathing in for a count of three out for five, or five and seven. Or any other breathing technique you know and use.
- Singing or playing a wind instrument are also good way to calm the system, for those for whom these options are relevant and appealing.
- Playing and dancing are good. So is yoga.
- Friends. The better the support network a person has the better their recovery from post-traumatic stress. Unfortunately, people whose early experiences led them to be wary of social relationships are statistically the very people most likely to suffer post-traumatic stress after negative experiences. And people who are traumatized tend to withdraw from the very social circles that could support their recovery. However, encouraging them to reconnect with people as much as they can, and to seek, accept and value any potential sources of social support, can be helpful.
- Joining a choir or a yoga class may offer not only a de-stressing activity but also a potential source of supportive contact. And yoga can easily be adapted to being a mindful activity (see below). Good yoga teachers put a lot of emphasis on noticing what is going on in the body.

MINDFULNESS AS A RESOURCE

Another potentially valuable help for trauma clients is to have some kind of mindfulness practice. However, THIS NEEDS TO BE DONE WITH EXTREME CAUTION.

Mindfulness is the ability to be present in the moment. It has been defined by Jon Kabat-Zinn, pioneer of the use of mindfulness for stress reduction in the West, as "paying attention in a particular way, on purpose, to the present moment and without judgment."

The ability to exercise mindfulness is cultivated by mindfulness practices, especially mindfulness meditation practices.

With traumatized clients, it is wise to be cautious. It is a matter of sensitive clinical judgment when a client is ready to bring any kind of Mindfulness into the recovery programme. For some people who have been traumatized, mindful meditation can terrify prospect.

The last thing they feel will support their recovery is to go into what they perceive as the deep black void inside.

I have had one client for whom even ten seconds of going inside and focussing on her breathing on her own was so frightening she would not even contemplate it. With me in the room with her, she could just about tolerate about 30 seconds but no more than that. On her own, she could not even think about it. She became really anxious just talking about it.

If you know or suspect that someone has a lot of split off trauma memories, they are probably not ready for mindful meditation. What is more relevant for them is grounding.

So, feeling their feet on the floor, or the chair they are sitting on, might be more helpful. Or squeezing their own leg. Often people prefer to find their own version or tell you the one they already have. These are also useful ways to help bring someone out of a dissociated state and back into the room.

Asking people to find what they feel is a safe space in their bodies means that when they start to take their attention to a specific trauma very briefly to start with, they can keep taking their attention back to the safe space.

When they are ready to move to the next stage, less challenging places than meditation to start are practices like walking mindfully or doing yoga mindfully. And from that they may go on to a meditation that involves focussing not on themselves but on something external – like the sounds that they can hear around them.

When they are ready, combining such a practice with noticing when their

thoughts stray from the task and taking them back to it can also help build confidence in being able to have some mental control.

Loving kindness and compassion practices, too, may be better suited to many trauma clients than meditation without an agenda beyond noticing what comes up.

If you do not have experience of using mindfulness with therapy clients, I would recommend that you read Mindfulness and Psychotherapy edited by Germer, Siegal and Fulton as well as doing your own mindfulness practice before you consider bringing it into trauma work.

Even better train in using mindfulness in therapy if you are planning to use it with clients. Some courses are better than others. If you cannot get a recommendation for a local one, consider online training. My own experience has been that I have found better mindfulness courses online than in the real world.

Many mindful practices start by focussing on the breath. Just that alone can be helpful for some clients when they are ready for it. It can be combined with teaching breathing techniques as above.

COMPASSION

Whether by mindfulness compassion practices or not, cultivating compassion for self is a key component of good trauma therapy.

I like to talk to clients about compassion and to discuss with them how they can show themselves more compassion in their lives. It can be less challenging to start with this broader consideration before you ask them to start to apply it to their trauma experiences.

What could they do in their everyday lives to be nicer to themselves? There are going to be as many answers as there are clients.

Besides what they come up with for themselves a short compassion exercise I also like to show people and to ask them to do as homework is a version of the butterfly hug. I think of all the homework practices I have asked people to do over the years this has probably had the best take-up and the best feedback.

The name comes from an EMDR practice used with children.

The idea is for a person to cross their arms, so they are holding the opposite upper arm with each hand, roughly midway between elbow and shoulder, and to tap their arms with their hands alternately.

This was devised originally by therapists on a humanitarian mission to a

refugee camp where they had a large number of traumatized children and a small number of therapists.

What they did was to have the children draw pictures of the home they had left. Then they looked at the pictures while giving themselves bilateral stimulation by tapping alternate arms as described above.

They would then draw a new picture. Comparing old and new gave therapists feedback about their progress. Most were processing their traumas for themselves. The ones who were not showing change were then given priority for the scarce one-to-one attention.

In my pre-EFT days, when I used EMDR with children, I taught a number to do this and often they told me it had been really helpful as in-the-moment first aid when they were upset.

My current EFT based variation of this is to say, while doing the alternative arms tapping: “I accept myself without judgment” or “I accept myself with compassion” or whatever seems most relevant to where a client is in therapy and/or which most appeals to them.

The EFT butterfly hug is combines tapping with the fingertips, which have some meridian relevance, bilateral stimulation by the hand, self-acceptance and a focus on being kinder to ourselves.

BRAKES FIRST

It is always important in trauma work to ensure you have good working brakes before you hit the accelerator.

Teaching people to tap, breathing techniques, doing things like yoga or singing in a choir, all help to have some braking system.

Within therapy, I like not only to encourage people to identify and use a safe place in their bodies, as outlined above, but also to identify or create a safe place to go in their minds.

There is a case for having them invent a safe place rather than use a place they know or have known. An invented and present tense safe place is unlikely to have any associations with traumatic experiences.

There is a kind of uber safe place visualization which I like to use with some clients before we do trauma work. It is a composite co-devised by a number of therapists over the years. It involves imagining being in a place with a see-through dome above and the same sort of dome below so that they are in a completely sealed environment. No one can enter without invitation.

Then, within the dome they can choose what sort of landscape it is. Field, meadow, wood, beach etc. It needs to be somewhere they invent and where they feel really safe.

I like to invite them to have in it a single-storey dwelling of some kind, but without basement or attic. They design it. They decorate it. But within it, or somewhere within the dome, they are invited to set up a kind of night safe – a place where they can deposit, but no one but them can withdraw and then only at a time of their choosing

In it they can put the metaphorical DVDs of memories they want to process at some time but where they can stay safely and away from current access until they are ready to work on them.

They are also invited to put a pool or a waterfall somewhere within the dome.

Some clients like to do this visualization for themselves between sessions.

One caution here: it is a fine line between visualisation and hypnosis. Most people will go into trance doing whichever you call it. This is particularly going to be true for those of you who have hypnosis training and probably automatically drop into a hypnotic voice.

For those of you less familiar with hypnotic states, people go in and out of trance all the time, but probably even more in therapy than elsewhere.

It may be, as people who study hypnosis claim, that high stress situations such as those that cause trauma, put people automatically into a trance state. Trauma has been described as a psych neurophysiological dissociation

One of my favourite hypnosis teacher's way back was Dr Brian Roet who used to say his favourite hypnotic induction was: "Close your eyes and go inside."

HYPNOSIS WARNING

For those of you who have hypnosis in your toolkit, I strongly advise against using hypnotic techniques to deal with specific traumatic memories.

I know a lot of people who do not know much about it are prejudiced against hypnosis. So, let me say I am not one of them. One of my early trainings was in hypnotherapy. I studied it extensively. I devised a course and taught a course in clinical hypnosis which was approved by the leading UK hypnotherapy body. I am not anti-hypnotherapy per se.

I know that in both hypnosis and NLP there are accepted techniques (screen, rewind etc) to this. But my concern about them is that they depend on dissociating people from the memory so that they are looking at it, not in it.

This would be good if you could guarantee that you could, and they could. No matter how good a client is at doing this, or how good you are at using hypnosis, there is no guarantee people will manage to stay dissociated.

And if a client does go into a "raw" unprocessed trauma memory they are likely to experience it even more vividly than they would in a non-hypnotic state. Hypnosis tends to turn up the volume on sensory and emotional information.

THE TRAUMA TREATMENT PHASE

As I have said it makes sense to start with awareness of body sensations and how to work with them before we go anywhere near specific memories.

When we are ready to process individual memories, we can sneak up. Ask a client how they feel about approaching the memories. Tap on any reluctance, anxiety, fear, or any other negative emotion or body sensation they identify before you go ahead.

The movie technique, tearless trauma and story-telling have been described earlier.

MORE TIPS FOR THE MOVIE TECHNIQUE

- Remember the distancing suggestions. You can put the DVD in another room – or on another planet.
- You do not have to get the SUDS to zero by the end of a session. I think keeping strict time boundaries helps client feel safer with us. If they are not zero, just check at the start of the next session. Once they start, they often keep going down by themselves.
- Don't start processing a trauma when you do not have a lot of time left in the session It a) risks a client not being in a good state to leave at the end of the session and b) violating a client's assumption that they are safe to bring up something towards the end of a session because that means they will not have to psych themselves up to do so next time. Clients often trust, if they know you are keeping strict time boundaries, that you will not start working on it until next time.
- When people think a memory is zero, test, test, test. Story-telling, as outlined earlier, is a way both to finish and test processing. Sometimes it brings up aspects that people unintentionally excluded completely from their movie.
- Then ask them to bring up the original memory and note changes. If it is less visually vivid, has a quieter sound track and/or seems longer ago or

further away that confirms that there has been some successful processing.

- If someone says they were in the original movie and are now outside watching it that dissociation is a good sign, too.
- To test that it is a really robust result, ask them to try to get the movie back to the way it was. Can they restore the colour? The soundtrack, move it back closer, make it more recent? If they can and the emotion comes back up, too, you are not yet done.

Of course, the real test is always what happens outside the therapy room. If it even better if a person reports that they feel different, that they experienced something that would usually be a problem for them, and it did not trigger a response.

When you are asking for a 1 to 10 SUDS measure on anything, whether it is a trauma memory of an anxiety response, and people say they cannot "do" SUDS in the conventional way just ask them to guess. Guessing accesses what we know unconsciously but do not consciously know that we know. It is surprisingly reliable. And it is a multi-use tool, not just for SUDS.

If you are working with a child, you can have them indicate intensity with their hands. Wide apart is 10. Barely apart might be a one or two. But once they reach the stage where they can do it in numbers, in my experience most love to do it that way.

SURROGATE TAPPING

Besides the use of the movie technique with an invented movie for experiences stored early in implicit memory outlined earlier, another option is to tap on the younger self.

The way I like to tap surrogately is to imagine I am the subject of the tapping. So, say you wanted to tap on a "memory" of being taken away from your mother and put in an incubator immediately after birth. It is not difficult to imagine/ guess how that deprivation of familiar environment, skin touch, voice and so on would feel.

There is also a good case for doing similar surrogate tapping for a self who was caught up in an event for which you have post traumatic amnesia. In this case instead of using the set-up "Even though I am … and inserting the name of the person you are tapping for, you would use something like "Even though I am my seven-year-old self… or "Even though I am seven and I am trapped in this water pipe and… and then switch to set-ups like: "Even though I feel so scared… "Even though I think I am going to die… and "Even though I cannot

breathe…

GENETIC INTERGENERATIONAL TRAUMA

There is growing evidence that trauma is transmitted through generations. What we are carrying may not actually have happened to us at all. But it may have marked us, nevertheless.

In a study published in December 2013 experimenters taught mice to link the smell of cherry blossoms with pain. Their off-spring, with no previous experience of cherry blossom, showed fear when they were first exposed to it. More recent work has shown the mechanism to be via RNA in the sperm of the male. And that the effects carried on to a third generation.

This comes as less of a surprise in the light of studies such as the one by a research team at New York's Mount Sinai hospital showing genetic changes stemming from the trauma suffered by Holocaust survivors are capable of being passed on to their children.

The study of 32 Jewish men and women who had been interned in a Nazi concentration camp or had witnessed or experienced torture or had had to hide during World War 2 found that their children had increased likelihood of stress disorders compared with Jewish families living outside Europe during the war.

They found epigenetic tags on the very same part of a gene associated with the regulation of stress hormones in both the Holocaust survivors and their offspring. The same correlation was not found in any of the control group and their children.

After controlling for other variables, the team concluded "The gene changes in the children could only be attributed to Holocaust exposure in the parents"

The focus of this research was specifically on finding the relevant genetic mechanism of transmission. But Bruce Lipton's work reminds us that our DNA is only a blueprint. Which genes are expressed is dependant largely on their environment? Change the environment, including the emotional environment – for example by tapping – and you change the likelihood that that gene will be expressed.

But there is no reason we cannot surrogate tap for ancestors and for the part of ourselves that carries their traumas and for the infant self-born with this genetic possibility.

When we tap on any negative or unwanted body feeling it makes no difference whether it comes from our own lives or from ancestral ones or past lives.

OTHER TRAUMA RESOURCES

Here are some additional resources to use with EFT in working with trauma.

CHOICES

Patricia Carrington's choices method is a useful tool to have in your trauma kit. (see www.Patcarrington.com).

In choices, the set up becomes: "Even though I have this … I choose to that…" The protocol is also slightly different. It is worth downloading Pat's manual from her website and familiarizing yourself with it.

Obviously in most situation if we could choose something different, we would. But by making choices like: "I choose to discover how to..." or something similar, then we challenge our unconscious minds to find a way.

Choices can usefully be pressed into service when we are helping clients to rebuild a new life and a new sense of self after we have used EFT to clear trauma.

Different explanations have been put forward for why something as seemingly simple as the movie technique can make the difference it often does in a traumatic memory.

We know that every time we remember something, we edit it in some way to make more sense of it from where we are now. What we return to our memory store is never what we retrieved. So, pairing the memory with tapping, which produces some physical relaxation of the body, with the memory useful.

We have evidence from random controlled trials that tapping on trauma reduces the level of such stress hormones as cortisol and adrenalin in the body.

This both produces the less aroused state which becomes paired with the memory and has wider implications over the whole 24 hours for people who have experienced trauma.

People with post-traumatic stress have maladaptive cortisol levels not just when something triggers the trauma but throughout the day. They have messed up sleep patterns. They wake which in turn messes up cortisol levels.

ADDITIONAL RESOURCES

Further reading:

Overcoming Trauma through Yoga: Reclaiming Your Body by David Emerson and Elizabeth PhD Hopper with foreword by Peter Levine and Introduction by Bessel M.D. Van Der Kolk

The body bears the burden- trauma, dissociation and disease by Robert C. Scaer

The biology of belief by Bruce Lipton

The body keeps the score by Bessel van der Kolk

The body remembers by Babette Rothschild

The brain that changes itself by Norman Doige

The genie in our genes by Dawson Church

Trauma and the Body: a sensorimotor approach to psychotherapy by Pat Ogden, Kekuni Minton and Clare Pain

Trauma and memory by Peter Levine

The Truth about Grief by Ruth Davis Konisberg

Unlocking the Emotional Brain: Eliminating Symptoms at Their Roots Using Memory Reconsolidation by Bruce Ecker and Robin Ticic

Waking the Tiger: healing trauma by Peter Levine

TRAINING COURSES

AAMET Trainers Craig Weiner and Alina Frank offer online trauma courses. Go to www.tappingtraining.com

NICABM offers trauma related courses from time to time. There are also a lot of trauma resources on the website. See https://www.nicabm.com/

OTHER RESOURCES

A fun song about polyvagal theory recorded at ACEP (Association for Comprehensive Energy Psychology) in the US which will make you smile – and help you check your understanding of it. http://tinyurl.com/jjxwuh6

To get a flavour of Bessel van der Kolk go to: http://tinyurl.com/zx9gmsu

Psychologist Amy Cuddy talks about how to use body language not to change the way other people respond to us but how we feel about ourselves. Really relevant for helping clients rebuild a post-trauma life and to feel confident in situations like job interviews. Only ten minutes long. Unfortunately, the video

quality is poor, but the message is worth it. http://tinyurl.com/zgvkj6d

To learn more about Patricia Carrington's Choices method go to www.Patcarrington.com