Chapter Nine

The Role Of Trauma In Community Health: A Somatic Perspective

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"Trauma is a fact of life. It does not, however, have to be a life sentence."
Peter Levine (1997, p.2)

Traumatic events are common experiences for clients in community mental health. Advances in Neuroscience and Psychology offer evidence of how fear, stress, and trauma impact not only the individual but family and community. Clients may not fully understand the effects of trauma or they may feel stigmatized by their experiences and will not seek professional help. Or, if they do seek help, they might not realize the extent of their symptoms. Historically, the complexity of trauma has not been fully understood and treatment was limited to a single diagnosis instead of treating the effects of trauma on the whole person and the community. "Despite the human capacity to survive and adapt, traumatic experiences can alter people's psychological, biological, and social equilibrium to such a degree that the memory of one particular event comes to taint all other experiences, spoiling appreciation of the present" (van der Kolk, Farlane, 1996, p.4).

Trauma is not an isolated event; it happens within the matrix of an individual's community, relationships and life circumstances and needs to be understood within this context. The overwhelm and helplessness that arise in the sufferer spans a range of traumas, from shock trauma, to relational trauma, natural disasters, war and early attachment ruptures. The event is important, but how the person has experienced it and how they are coping is equally significant. Clinicians are now considering the complex and contagious nature of trauma, how it spreads to various parts of the body and psyche. Clinicians also understand that "not every traumatic event results in traumatization" (Turner et al., 2001, p.74). What makes an event traumatic? And what exactly is trauma? And if trauma impacts body, psyche, and community as well as possibly the treating clinician, do we not need treatment modalities to address these complexities holistically?

"Central to the experience of traumatic stress are the dimensions of helplessness, powerlessness, and threat to one's life. Trauma attacks the individual's sense of self and predictability of the world" (McFarlane & Girolamo, 1996, p. 136). Viewed on a spectrum, trauma can range from mild stress that is manageable to overwhelming stress that turns into traumatic activation. Social milieu, personal circumstances, and the frequency and sequencing of traumatic events (single event, multiple events, or a complex relational trauma) make a difference in the longevity of trauma recovery. Trauma affects the whole person. "The human

response to psychological trauma is one of the most important public health problems in the world" (van der Kolk, 2003, p.168). It is an experience that dramatically alters the course of the sufferer's life. Trauma has a ripple effect, impacting those whose lives surround the client. The suffering of the trauma survivor impacts spouses, children, and communities. Effective trauma treatment needs to address the psychophysiological experience as well as the social-emotional impact.

The savvy trauma therapist works not only with the characteristics and symptoms of trauma, but takes into consideration the personal, societal and relational aspects of the client's life. Trauma can be devastating and can leave long lasting emotional and physical consequences. From a somatic perspective, therapists expand and integrate the body's own responses and resources. "Somatic resourcing begins with the therapist's ability to recognize the client's health, rather than only the pathology, acknowledging that despite significant traumatic experiences, each client already has a rich variety of resources intact" (Odgen & Minton, 2006, p.233). Therapists look for what strengths and abilities the client has that can be build on. Somatic resources generate an awareness of the sensations in the body that feel pleasant and grounding for the client and help them mediate the debilitating symptoms of trauma.

Traumatic stress is not defined by the event but by how the person experiences it. The body responds psychobiologically with primitive survival instincts towards safety and survival. The trauma survivor naturally attempts to make sense of what happened and to cope with the aftermath of traumatic memories. To fully understand the traumatic experience, we need to look not only at what happened but also how the body remembers the trauma and continues to live with it. "Traumatic memories appear as somatic sensations which can be transformed into communicable language only to a limited extent" (van der Kolk, 1998, p.77). Traumatic memories store in the body "and can be named through direct body contact; pain can be connected with the original feelings of unlived rage, grief, shame, or fear and thus become accessible to processing" (Karcher, 2004, p.412). The clinician needs to discern what meaning the client currently attributes to the traumatic experience, assess what strengths and resources the client has developed to cope with the traumatic symptoms and understand how the client's somatic experience of the trauma has developed into bodily symptoms. Therapists need to learn how to assess and interact with these bodily responses to help the client navigate the short and long-term effects of trauma. In addition the clinician needs to learn how to regulate their own levels of stress and care for their own mental and physical well-being in preparation and avoidance of vicarious traumatization.

TRAUMA AND THE BODY

Trauma sufferers know that their experience is not just 'in their head'. They live with the trauma's physical sides: night sweats, trembling hands, nervous sensations in the belly, eyes scanning for safety are some of the daily occurrences. "Trauma is something that happens in the body. We become scared stiff or, alternately, we collapse overwhelmed and defeated with helpless dread. Either way, trauma defeats life (Levine, 2010, p. 31). Our bodies are smart, and equipped for stress, and even for trauma. Our resilient nervous system activates the sympathetic

response when we are excited and the parasympathetic branch when we need to rest and restore. The back and forth movement between these two body systems ensures that we can handle minor stresses, experience pleasure, and restore ourselves with excitement and fun. It also helps us in moments of danger. We activate branches of the sympathetic nervous system when we need to take quick action, respond to danger, and recuperate through the parasympathetic towards release and rest. Arousal is natural, something we need to feel excited, alive, and active in our bodies. "The body initiates and the mind follows" (Levine, 2010, p. 135). When fear, terror, and powerlessness overtake normal emotional responses, the client's arousal level goes into survival mode and propels the client into either a state of extreme action (fight or flight) or suppression of impulses (freeze). What causes one trigger to be more active than another? This is an important question to consider since trauma clients often report seemingly minor incidents as very threatening. The more our basic attachment to and safety with others are threatened, the more potential a trigger has to be activated. A seemingly harmless event can cause memories of threat or loss and flood the client's awareness.

Mammals are wired to handle stress with an ability to take quick action and then rest when the danger is over. We can cope with great stress for a period of time when it is followed with rest and integration. The followed resting period is crucial for recovery and integration. Trauma states exist on a arousal spectrum in the body. On one end, there are low stress levels, which the body can handle when it is followed by a rest period. On the other end of the spectrum, there are high trauma states, characterized by overwhelm and terror, which the client can't regulate. If traumatic stressors do not subside, or the activation of the stress response is constant without integration, the client becomes chronically stressed or overwhelmed. The chronic nature of stress and the non-integration of previous traumas can lead to the inability to integrate or dissipate the levels of stress in the body. Even normal mild stressors of life become overwhelming and depressing for the trauma client. Anxiety, excessive worry, and a range of panic responses mark a hyper-aroused state. These are not static experiences but continually moving and responding to how the client perceives a situation. A hypo-aroused client often experiences a more depressive, numb and dissociative spectrum of trauma response. The flat affect of this client mimics the death-like expression of a prey in hiding. An informed trauma therapist includes the biological responses as well as teaches the client to learn 'how to be with fear'. Effective trauma therapy needs to teach clients how to differentiate the psychobiological responses of the body with the associated negative affect. "Separating the two components breaks the feedback loop that rekindles trauma responses" (Levine, 2010, p. 58). The client begins to successfully interrupt negative emotions associated with the overwhelming body responses.

STAGES OF THREAT RESPONSE

There are several stages in the way that our bodies respond to threat. These responses, defined by Peter Levine and Pat Ogden (2010, 2006) move quickly through the bodies defense systems and can be tracked by the therapist. Due to the overwhelming emotions experienced during the original trauma, these responses are likely frozen or stuck in the client's body and

psyche. Hyperarousal cues need to be observed carefully. “Hyperarousal reflects the persistent expectation of danger” (Herman, 1992, p.35). By noting mindfully where the client got stuck within the following sequence the therapist can aid the truncated body responses towards more healthy impulses as well as regulate hyperaroused symptoms.

Alert Arrest: This is the initial awareness of danger on a subtle level. The orienting response engages, where one evaluates the origin of the stimuli. There is a temporary stopping of activity and active listening. The attention is focused on identifying the source of potential threat. The body becomes still and completely orients towards the stimuli.
Startle Response: This happens almost simultaneously with the alert arrest. The startle response has high sympathetic nervous system arousal and there is an immediate action response towards physical mobilization.
Defense Orienting Response: When the threat is assessed as high and requires action, the body activates and prepares for multiple action responses, such as fleeing, fighting or freezing.
Action Responses Fleeing/Fighting: The body evaluates for the necessary action response. If there is a chance to flee, the flight response will be activated. If not, a fighting response might be necessary. The body will move into running, pushing, fighting to increase chances of survival.
Completion: If the threat does not actualize, the body’s physiology returns to resting and release through a natural self-regulation process. The high activation level is released. There can be an emotional release; trembling or strong affect as the body restores and realizes the threat level has been mastered. Completion also happens when the fight or fleeing response was executed successfully. After the action of fighting or fleeing, the body gets restores by releasing and resting.
Action Response/Freezing: When fight or flight is not possible or becomes overwhelmed or defeated in the face of a continuing threat, the physiological response is freezing. The body uses this response as another chance for survival. The activation level is high but is brought to a halt on external cues, e.g., the person looks frozen as a last defense towards surrender.
Completion Freezing: When the threat is over and safety returns, the freezing response gets discharged through body tremors and emotional expression. However, if there is no perceived safety the body becomes symptomatic. The stuck freezing response is one of the therapeutic challenges as the client can get easily re-triggered into freezing states or live in constant vigilance with freezing tendencies, as the original trauma is not processed.

CLASSIFICATIONS OF TRAUMA

We can categorize trauma into single occurrence and multiple traumas. Shock traumas that are single occurrence include events, such as a car accident, while multiple complex traumas include events that unfold over a longer period of time, such as early childhood abuse and neglect. “Shock trauma, originally defined by Freud as a breaching of the protective barrier, can be differentiated from developmental trauma. Developmental trauma involves interruptions or distortions in normal development, which results in characterlogical patterns that impairs healthy functioning (Eckberg, 2000, p.1). It is crucial to discern if the client has had single occurrence or

multiple traumas, for the nature of the trauma impacts the treatment options. Early childhood abuse, followed by more trauma in the form of domestic violence is treated as chronic trauma. Ongoing, serious medical conditions and invasive treatments are also classified and treated as chronic trauma. Each categorization has a unique impact on the therapeutic relationship.

Classifications of trauma:
Shock trauma: often single episode
Developmental trauma: occurs in childhood, impacts the developing brain and body and the natural development of the psycho-emotional stages
Complex trauma: multiple and layered trauma, a combination of early developmental and shock trauma, may become chronic
Duration and severity:
Short term impact: effects are short-term, crisis is immediate but does not become chronic
Chronic trauma: prolonged symptoms that affect many functions of life

POST-TRAUMATIC STRESS DISORDER (PTSD)

Post-traumatic stress disorder is a mental health disorder that follows a terrifying event. PTSD can arise after experiencing a serious physical, emotional threat to one's body and health or witnessing a severe event that involved death or serious bodily harm. The estimated prevalence of PTSD among adult Americans is 7.8%, with women (10.4%) twice as likely as men (5%) to have PTSD at some point in their lives ("Posttraumatic Stress Disorder" 2011). Often clients don't recognize the symptoms of trauma and are dealing with anxiety, fear and depression on their own. Many trauma clients do not seek therapeutic assistance right away, either because they don't take the traumatic experience seriously or they think that "time will heal" or because of shame and guilt. Our human responses to trauma are complex and the variety of symptoms, especially somatic symptoms, makes it challenging to accurately diagnose. According to van de Kolk, it is important to address three key areas, such as safety, anxiety management and emotional processing in the successful treatment of PTSD (van der Kolk, 2003, p. 188). Symptoms vary in range and presentation and can be quite comprehensive including:

- Various somatic complaints, often with no medical explanation
- Shame, guilt, self-blame, survivor's guilt
- Addiction and substance abuse to cope with symptoms
- Re-experiencing the traumatic event, such as flashbacks, nightmares, intense physical and emotional distress, muscle tension, and triggers.
- Avoidance and numbing, such as loss of interest in life, feeling depressed and bleak about the future and emotionally numb.
- Increased Anxiety And Emotional Hyperarousal, such as irritability, outbursts of anger, feeling jumpy and startled.

("Postraumatic Stress Disorder" 2011, DSM Kolk, 2003, p.171,; DSM-IV-TR, 2000, p.218; Briere, 2004, p. 39-69 & 123; Eckberg, 2000, p. 4).

WORKING WITH TRAUMA FROM A SOMATIC PERSPECTIVE

The body offers cues we can learn read as therapists. When we track body cues independently from content, we can train the eye to "see and hear" the body's voice rather than the story told with words.

Tracking the body

"Tracking refers to the therapist's ability to closely and unobtrusively observe the unfolding of nonverbal components of the client's immediate experience: movements and other physical signs of autonomic arousal or changes in body sensations" (Odgen, 2006, p.189).

Tracking is the method by which the therapist sees what is occurring in the present moment of the client without judgment. It is the art of seeing even the most minute details of the client's expression. Humans are naturally tracking all the time: part of our hard-wired survival circuitry is to carefully observe others. The way the upper lips curls might reveal a moment of contempt, a quick glance out the corner of the eyes might reveal a fearful emotions. Tracking the cues of the body can point towards the inner life of the client. Tracking is the art of seeing underneath the content, the story that is being told and listening to the story that is actually happening in the present moment. "As body psychotherapists, we carefully observe client's nonverbal expressions, postures, facial expressions, gestures, movement patterns, and general patterns of relating. We 'read" all that for what is says about the underlying rules, the experiences that created them and how they are still shaping present experiences" (Kurtz, 2006, p. 19). In addition the advanced body-psychotherapist tracks for his or her own inner experience and body in relation to the client's material. Some of the body cues to track with clients are:

- Tone of voice: Relaxed or tight? Fast or slow?
- Skin tone and color: Flushed, going pale?
- Facial expressions: Expressive, flat, held with tension?
- Body posture: Open or closed? Hunched or tight?
- Eye contact: Direct or hidden? Aggressive or shy? Vacant or present? Scanning the room?
- Breath: Slow and even? Held and fast? Belly breathing or upper chest breathing?
- Gestures: None or many? Repetitive gestures? Unusual ones? Gestures that indicate a stop, or defense of some kind?
- Relational posture towards therapist: Open and curious? Closed and inward?
- Movement cues: Rocking or still? Expressive, dramatic or stiff and disconnected from other parts of the body?
- Sensory-motor impulses in the body: Twitching legs? Hand and arm movements that want to push or defend or protect? A sudden head movement?

- When tracking these body cues, we want to understand them in the context of the client's present experience and what they are reporting. For example scanning eyes and a narrative of feeling watched might indicate an inner state of anxiety.
  (Hakomi Institute Training Manual, 2011)

Completing Somatic Responses

The client learns to embody safety through the release and integration of the traumatic impulses. This cannot happen without a caring, safe, and empathic relationship. When neuroception (the ability to sense safety or danger) tells us that an environment is safe and that the people in it are trustworthy, we can then behave in ways that encourage social engagement and positive attachment (Porges, 2010). Working with the body within a caring and safe relationship sets up the ideal environment to restore psychological health.

When we track for trauma cues in the body, we look for stuck bodily impulses that froze when the client was overwhelmed in the moment of physical danger "When we are frightened, we are dependent on the neural circuits that evolved to provide adaptive defensive behaviors for more primitive vertebrates. There neural circuits provide physiological mechanisms that reflexively organize mobilization or immobilization behaviors before we are consciously aware of what is happening" (Porges, 2010, p.19). The impulse to free oneself still lives in the body as a response appropriate to a threat. This impulse can be tracked by observing the minute expression of a twitch in the upper thigh or a halted, almost invisible kick of the foot. The somatic therapist tracks these cues, slows them down, and brings the mindful attention of the client to this part of their body.

The client can then be aware of this impulse, "stay with it", and find its natural completion, for example a full and extended 'kick.' The sensory-motor cortex now expresses that which was frozen or overwhelmed. The body is able to complete the response and the symptoms (e.g., chronic tension) or emotions that could not be expressed before can now release. It is crucial that the client release these physically truncated responses with awareness and mindfulness so they can now be present with what is happening—something that is often missing in the moment of overwhelm.

When the client is able to stay present and follow the body's innate restorative capacities, the completion of the trauma cycle can occur and the body is reset and restored. Suffering is eased when the client can "move through the bad and difficult sensations, opening to those expansion and goodness" (Levine, 2010, p.80). Integration of traumatic responses happen in the process and movement when the therapist "assist(s) clients to oscillate between the two conditions of competence and traumatic reactions appears to help integrate trauma responses, prevent the reactions from escalating, and deepen feelings of confidence and mastery" (Odgen, 2006, p.246).

Three-Phase Model Of Trauma Recovery

There are three distinct phases of trauma recovery that have been identified by Pierre Janet, a

French psychologist and pioneer in the field of dissociation (Herman, 1992, p.156). Janet distinguished ordinary memories from traumatic memories and discovered that the trauma memories were not easily accessed under "ordinary conditions and beyond conscious control. "The memories of his patients consisted of sensory experiences, emotional states, intrusive recollections, and behavioral re-enactments. (Janet, 1889, 1919/1925; van de Kolk & van de Hart, 1989, 1991, van de Kolk, 2001, p. 35) He identified three crucial recovery phases:

1. Stabilize safety needs
2. Process trauma memories
3. Integrate the memories and resolve them into daily life

Janet's basic phase model can be expanded to include the somatic aspect of trauma healing as mentioned by Eckberg, 2000, Odgen, 2006, Fisher, 1999, Levine 2011. Including the client's somatic awareness with psycho-education creates a base from which the client can safely integrate traumatic memories.

Phase 1: Co-creating Somatic Resources and building Safety within the body

During this phase, clients learn about their own states of arousal. As the client gains confidence in recognizing arousal, the therapist begins to help develop resources that are psychophysical such as somatic resources that focus on safety and stabilization of trauma symptomology. "Somatic resources that involve awareness and movement of the core of the body (centering, grounding, breath, alignment) provide a sense of internal physical and psychological stability and therefore support auto-regulation. Somatic resources that develop awareness ad movement of the periphery (pushing away, reaching, locomotion) tend to facilitate capacity for interactive regulation" (Odgen, 2006, p.222). The client learns on a concrete level how to resource towards an inner stability and capacity to be with emotional and physical states without being overwhelmed.

In addition, Psycho-education teaches clients how to understand and track for what is safe and what is not. They learn how to recognize states of activation and how to calm these activations with specific tools. The goal is to stabilize, understand how to calm themselves, and utilize emotional and physical safety and resources. Simple mindfulness techniques can be helpful to stabilize arousal cues and return the client to a regulated inner state. "Resources are the material that lead to empowerment. Resourcing helps deactivate post-traumatic states such as hyperarousal or freezing. Resources facilitate presence. They support the return of our souls to the here and now" (Turner et al., 2001, p.77).

The therapist tracks the body to be sure that clients don't become too activated. At this stage the therapist actively modulates the arousal. The focus is on calming the trauma symptoms and not let the client re-experience the trauma. "The trauma survivor has symptoms instead of memories" (Fisher, 1999, p. 3). The therapist models through their own calm state a way-of-being for the client, as Fisher (1999) says, "Modeling should ideally begin at the very first contact with the patient, whether over the phone or face-to-face. Modeling has two purposes: it indirectly teaches the patient new skills and it directly offers the patient an experience of

protection and safety, which he or she may never before have had. What we want to model is our constant concern and interest in safety and self-care" (p.3). The therapist also works with the client to maintain regular life rhythms: sleeping, eating, and modulating basic metabolic issues and initiating healthy habits of self-care and stabilization of symptoms.

Phase 2: Processing and integrating memories, sensations and experiences into the whole body experience.

In this phase the client learns how to differentiate and tolerate sensations, feelings, and sensory intrusions. Rather than just looking for safety, the client learns to tolerate more intense feelings and sensations and is able to regulate their affective state with the help of the therapist. The client learns how to identify and embody resources that helped them cope in the past and add new ones. The client can now experience physical impulses that emerge when a memory is evoked and are able to track their fight, flight, freeze responses. They are also able to follow through with these survival impulses on a sensory-motor level so the body can complete any truncated responses towards resolution. The client has a new experience: the survival impulse is now coupled with mobilizing responses that were not initially available. "Fundamental to this process is uncoupling the fear or terror from the freezing response. It is essential to keep the client grounded in sensate experience, to slow the process down when necessary, and to encourage blocked defensive and orienting responses, felt as micro-movement, to come through" (Eckberg, 2000. p. 53). These micro-movements are often welcomed as a new experience that moves the client out of the familiar frozen state and restores pleasure and well being.

In this phase it is helpful for the therapist to identify and discuss the type of trauma or traumas, e.g., attachment, shock trauma, or others, the client has experienced. The therapist is actively engaged with the action systems of the body by encouraging movements of the body that have been held back or needing and empowering the mobilizing defenses that were truncated during the original event. This is a more intense stage of the work and the therapist needs to track for possible regression into earlier safety needs and fears. The therapist focuses on integrating memory and meaning-making into healthy body experiences. The therapist continues to introduce calming and grounding techniques, not just for resourcing but for showing the client a way to "be" with their arousal states. "Grounding" refers to the ability to have not only our "feet on the ground" but our "minds on the ground" (Fisher, 1999, p. 5). The therapist works with the client to understand the impact of traumatic events in their life and helps them begin to make sense out of what has been senseless before by integrating the fragmented memories, associations, imagery, and dreams.

Phase 3: Embodiment Of New Choices

At this stage the client gains emotional and physical confidence. The traumatic memories are no longer a primary focus and there are signs of relief and change. The client experiences the body as an ally rather than as something to be avoided. They can now integrate resources learned in earlier phases into daily life. They develop an increased capacity to access their somatic

experience by choice. Safety becomes internalized, and there is more room for other life discoveries and expansion. This stage focuses on integration of traumatic memories and in making new life choices. The therapist helps the client realize new cognitive meanings and connect them with the somatic experience in the present moment. "Orienting and defensive responses are restored, as well as an increased capacity to modulate arousal in the nervous system. The gap between pre-traumatic and post-traumatic identity closes, and there is more integration between the two" (Eckberg, 2000, p.61). The therapist looks for opportunities to highlight opportunities for wellness, integration, and completion and placing the traumatic memories in context of the client's current life.

SHAME

"Shame is just like all of our emotions and feelings—it is necessary for our survival" (B. Rothschild, 2010, p. 27).

Shame is part of the trauma journey and can complicate recovery since it is often hidden or experienced by the client as stifling. Resolving shame is crucial for recovery and health. Shame can have many facets. "It is the sense that one has let oneself down, that one was not able to meet the challenge" (Eckberg, 2000, p. 22). The survivor may feel ashamed of their own actions or believe that what has been done to them violates their religious beliefs. This may be especially true in sexual assault, rape, physical assault, humiliation, or authority abuse. Rothschild (2010) states that shame "often it has to do with an inner feeling of letting oneself down, not being able to protect the self" (p. 88). The tendency is to withdraw emotionally and physically when shame arises. Shame creates an involuntary response of the body, which can include sweating, heat in the body, the urge to withdraw, little eye contact, a heightened sense of awareness, and vigilance towards the surroundings and the actions of others. "Like fear, it (shame) is a "fast-track" physiologic response that in intense forms can overwhelm higher cortical functions" (Herman, 2007, p. 5).

The consequence of shame is that the person feels alone in their experience as if they are the only one having the response. This disconnection from others and their bodies can keep the shame experience alive for a long time. Not wanting to remember or talk about the event is part of the experience. The therapeutic stance when facing shame should be one of compassion, kindness, and respect for the shame itself as a protective mechanism. When shame is acknowledged and held kindly by the therapist, the intensity of the experience wanes. "Shame needs three things to grow out of control in our lives: secrecy, silence, and judgment. Shame happens between people, and it heals between people" (Brown, 2010 p. 40).

MINDFULNESS

"Mindfulness is undefended consciousness" (Kurtz, 2006, p. 23).

Mindfulness cultivates focused attention on the more subtle aspects of body awareness, breath, and cognitive patterns in the present moment. Recent studies on mindfulness have shown that it benefits mental and physical health. Mindfulness is an inner-directed attention, that slows down physiological and mental states through a present-moment awareness. Mindfulness can be described as " the moment-to-moment attention to the details of experience" (Wegela, 2009, p. 58). Mindfulness slows the client down so they can notice their body and step out of "talking about" the paradigm of trauma recovery and learn by observing their inner experience without being triggered." Trauma can leave the client mentally and physically scattered. There may be a quality of speed and disconnection in the body. By learning how to focus one's attention the client can feel, sense and 'be with' himself or herself and find out what is helpful and healing. Briere states: "Because mindfulness allows us to stay present in pain, it supports the mind's ability to process painful aspects of the past" (Goldstein, 2010). This self-observation helps the trauma clients to know internal triggers and avoid habitual reactions.

Mindfulness also stimulates regions of the brain that integrate experience and calms activated centers of the brain such as the amygdala. In a 2007 study conducted by UCLA researchers, scientists discovered health benefits of mindfulness practice. "We found the more mindful you are, the more activation you have in the right ventrolateral prefrontal cortex and the less activation you have in the amygdala. We also saw activation in widespread centers of the prefrontal cortex for people who are high in mindfulness. This suggests people who are more mindful bring all sorts of prefrontal resources to turn down the amygdala. These findings may help explain the beneficial health effects of mindfulness meditation, and suggest, for the first time, an underlying reason why mindfulness meditation programs improve mood and health" (Nauert, 2007, Crewell 2007).

With a mindful present-moment focus, the client gains an internal witness that can help regulate the complexity of trauma symptoms. Mindfulness encourages acceptance rather than avoidance and can provide a tool in facilitating exposure to feared stimuli. "Learning Mindfulness techniques can strengthen the hub of the mind so that internal sensations, such as bodily signals or waves of emotions, can be experienced with more clarity and calmness. (Siegel, 2010 p. 133) Mindfulness can aid the trauma sufferer to be and stay with their experience in their bodies. Mindfulness is a tool to increase psychological awareness and flexibility when responding to emotional experiences (Follette, 2006, p.310). In addition the therapist helps stimulate the regions of the brain responsible for observing their own experience and being able to being curious about their inner experience. "The capacity to maintain observation of internal experience is what can prevent clients from becoming overwhelmed by the stimulation of past traumatic reactions and develop "mental coherence"" (Siegel, 2006, Odgen, 2006, p. 169). The quality of non-judgmental, moment-to-moment awareness allows the trauma client to find trust their experience and discover new healing capacities. "An operational working definition of mindfulness is: awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to unfolding of experience moment by moment." (Kabat-Zinn, 2003, p.145)

VICARIOUS TRAUMA AND COMPASSION FATIGUE

"All Emotions are contagious… Both the ones that are pleasant and the ones that are unpleasant" Babette Rothschild, 2006, p. 9).

Empathy is one of the "tools" used by the therapist to feel and sense a client's reality. The therapist's capacity for warmth, caring, and empathy is a crucial aspect in helping the client heal. The emotional state of the client can affect the therapist through "unconscious empathy," a process outside of the therapist's awareness. The mirror neuron system of the body mimics the emotional state of another; therefore, we can sense and feel though our perception and action system what the other person is feeling (Iacoboni, 2002, p. 4). "The practice of observing one's own mind and the minds of others builds in a layer of processing via increased integration between the middle prefrontal cortex and limbic regions, creating a broader perspective and a sense of confidence and stability, often followed by increased compassion (Badennoch, 2010, p. 464, Siegel, 2007) Through our bodies and empathy we can perceive the inner world of the other. It's also how we can become overwhelmed if we don't practice self-care. Listening to stories of pain and suffering can wear down the therapist. The therapist can suffer burnout or compassion fatigue and, in the worst-case scenario, suffer from vicarious traumatization. Compassion fatigue and burnout are normal responses to work overload and the chronic stress associated with working with trauma clients. Vicarious traumatization is a more serious step as the accumulative stress now begins to negatively affect not only physical and mental health, but alter the perceptions and beliefs of the therapist. "The observers and listeners have not actually been exposed to the event, though they can really feel it" (Rothschild, 2006, p. 15). The therapist's nervous system will respond and feel the impact of the event when listening to the victim's emotions, through the "capacity to experience what others experience" (Stern, Rothschild, 2006 p.10). Typical feelings can include, "I don't know how to help," "It's too much," "I feel sad or angry every time the client talks about it." Research on compassion fatigue points to therapists being particularly sensitive to it if their therapeutic success is ambiguous, they practice in isolation, and are emotionally drained by compassionately listening to suffering (McCann & Pearlman, 1990).

Vicarious traumatization is a cumulative process. It affects therapists across the range of clients, which distinguishes it from counter-transference. The effect can intensify over time and with multiple clients. "Vicarious traumatization, in particular, is a sign that a client's history is having an extreme effect on the therapist" (Rothschild, 2006, p.15). Vicarious trauma is pervasive. It affects all areas of one's life, including emotions, relationships, and one's views of the world. Its pervasiveness distinguishes vicarious trauma from burnout, which generally refers to the effects of concrete stressors, such as one's physical environment and work hours. Engaging with other professionals, learning about the effect of trauma on the clinician but most importantly not isolating oneself in the work.

Some symptoms of Vicarious Trauma include intrusive images, nightmares, emotional numbness, dissociation, exaggerated startle response, and a general sense of a being unsafe. The vicariously traumatized therapist will retreat from activities from normal life and work performance and productivity will decrease. They may use drugs or alcohol to self-medicate. At

this stage the therapist becomes ineffective in treating the trauma client as their level of identification and care for the client has blurred professional boundaries.

Self-Care and Resourcing for the Therapist

How does the therapist recover and restore? Taking good care of oneself physically, nutritionally, and mentally are essential to maintaining a good inner and outer health. Whatever restores the body-mind is essential to keeping a good attitude about how to face suffering every day. Nurturing spiritual values and emotional health are important to tune our empathic capacities. Basically we need to resource what makes us happy in our daily lives. "Spending time listing our own resources and calling up the 'felt sense' of them is a worthwhile activity, as is time spent developing new resources" (Turner et al., 2001, p.79). True empathy is being deeply attuned with other but also with ourselves by not taking on the pain of others.

Another kind of self-care happens within the work itself. It is important to remember to resource oneself as a therapist when things get overwhelming and intense. This can be done by making small shifts in the posture, connecting with breath, breathing calmly, and grounding. This may need to be done many times during a session. The way we resonate with another is through our bodies and emotions. Rothschild encourages the therapist to mimic another's posture or movement, resulting in "empathizing with his physical and emotional state" (Rothschild, 2006, p.65). But therapists need to remember not get lost in this empathic exchange. While noticing the impact of the client's story, return to what restores and grounds. Coming back to the mindful awareness of our body many times during the session can prevent burnout.

Another aspect of self-care is to periodically check one's attitude towards the job itself. Therapists can get caught up, get too close, or not close enough. Assume that client's stories will have an impact. Check your attitude towards suffering and pain. Can I handle it? Have I been there myself? Is it too much? Am I afraid of the client's story? Can I really help? Do I want to help? Is it my duty to help? Check your beliefs about this and notice where you get caught. How do you take care of yourself? The therapist utilizes empathy and warmth to understand the client and initiate change through the therapeutic relationship. It is vital that the therapist fine-tune the craft of empathy and care by restoring and periodically evaluating their level of burn out.

CONCLUSION

In community mental health practice, trauma recovery is a critical component. The therapist who can be present with the suffering of their client, by listening empathically to the story told in words as well as the story told by the body can be of great service. Emotional warmth and empathic attunement is critical to understanding the inner world of trauma, as well as the ability to assess and intervene to alleviate symptoms. By carefully tracking the language of the body, the therapist will learn how the trauma event has shaped the client from the inside out. In teaching the client to utilize mindfulness in the client, as well as being mindful themselves, the therapist is able to accompany the client on their healing journey as they uncover their own resources and

recover emotional stability. A crucial element in the recovery of trauma is how the client regains embodiment. What has been taken from them is essentially how to be in their bodies in a safe and stable way. “Embodiment is about gaining, through the vehicle of awareness, the capacity to feel the ambient physical sensations of unfettered energy and aliveness as they pulse through our bodies” (Levine, 2010, p. 279). It is this sense of embodiment that has been disrupted though trauma and can be restored by learning how to safely return to the sensations and emotions of the body. As most trauma occurs in relationship to others, it takes a safe and nurturing bond to reverse its devastating effects.

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