

The word “feeling” has a double meaning, referring to both emotion and physical sensation. This reflects SUE ROXON’s use of physical therapy to relieve physical symptoms such as chronic pain, which is part of an ongoing stress response to repeated and profound trauma. Here she discusses her work with survivors of torture and trauma.

Feelings are Physical

a somatic approach to post-traumatic stress

The way you organise your body - the way you sit, stand, and move - is not just a reflection of your emotional state. It is the manifestation of your emotional state.

Try this exercise. Allow yourself to slump, so that you can feel your breastbone drop down a little towards your pubic bone. Notice how this affects your ribs, and restricts your breathing. Let your head move a little forward in relation to your shoulders, and compress the back of your neck. Slightly shrug your shoulders, and bring your shoulder blades slightly closer together at the back. Tighten your jaw, just a little, and your cheeks. Crease your forehead into a slight frown. Tighten your belly a little, and your inner thighs. Reflect on your physical sensations. How would you describe your emotional state? If you continue sitting in this posture, do you find you have particular thoughts or feelings that accompany it? Can you imagine how you would feel and where you would develop pain if you maintained this posture for a long time? Now, think of the most recent happy, joyous event in your life. Even to help your memory, but certainly to re-experience the sensation of joy, you will have to change your posture. When I have given this exercise to an audience in a lecture, I notice that everyone immediately lifts their breast bone - reverses the slump - when trying to think of a time when they felt happy.

As a physiotherapist, I was trained within the Western medical model, which conceptually separates the psyche from the soma - the mind from the body - both in diagnosis and treatment. Even the distinction between the two professions, physiotherapy and psychotherapy, is based on a clear differentiation between mind and body.

I find this model to be inadequate in providing a useful understanding of human functioning, am frustrated by its mechanistic interpretation of physical symptoms. I needed a way of working that allowed me to address, via touch, the somatic symptoms (mostly chronic pain) of which my clients complained while fully acknowledging the impact of the traumatic environment in which such symptoms developed.

The easiest way to avoid struggling to connect the soma with the psyche in a practical and effective way is, simply,

to avoid separating them in the first place. Feelings are physical. A disembodied emotion is a meaningless concept. You only know what you feel, you only know that you feel, by your physical sensations. You know you are sad because you have, for instance, a heavy feeling in the chest, a lump in the throat, your eyes prickle with tears. You know you feel frightened because your heart thumps in your chest, you feel a sinking sensation in your stomach, and prickling armpits. Shame burns and guilt bites.

If we change the way we organise our bodies, our feelings change. Conversely, our bodies change as our emotional states change.

Think back to the experimental posture, commonly seen in survivors of long-term repeated trauma, whose physiology has been dominated for so long by the arousal of the sympathetic nervous system (the body's instinctive, defensive 'fight, flight or freeze' response to danger) that it seems to have lost the ability to switch off its defence response when it is no longer needed to ensure survival. Bessel van der Kolk, in 'The Body Keeps the Score', details the precise physiology - as far as it is known - of such survival mechanisms, traumatic stress reaction and the development of Post traumatic Stress Disorder.

This posture has been described by somatic psychotherapists as 'collapsed', 'defeated', 'withdrawn', and 'protective'. A history of threat and accompanying powerlessness can be seen in it. Psychiatrists may see it as 'depressed', while a naturopath might interpret it as indicating adrenal gland exhaustion (the adrenal gland being the organ which secretes the hormones of sympathetic arousal, as well as the hormones that switch such arousal off). Of relevance to physiotherapists, is that the maintenance of such a posture, with its pattern of constantly tight muscles, such as those at the back of the neck, combined with constantly underused muscles, such as those that extend the spine, will lead to stiffness and rigidity, weakness and fatigue, loss of flexibility and range of movement, loss of physical pleasure and sensory awareness, and chronic pain. Combined with the shallow breathing, it presents a picture of severely reduced functioning.

Jana was a 48-year-old woman from the former Yugosla-

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via whose husband had been murdered in the war, at the same time as she was separated from her son and imprisoned in a concentration camp. During this time she both witnessed and was subjected to horrific brutalities. She was reunited with her son at the end of the war and came to Australia. She came to STARTTS suffering from nightmares, insomnia, frequent flashbacks, intrusive thoughts and images, severe anxiety, panic attacks, fear of crowds and strangers and a feeling of deep dread. She received intensive counseling for many months, which reduced the intensity and frequency of these symptoms, to the point where she was able to attend English classes and lead a more normal life. She was referred to me because she still suffered constant headaches, frequent migraines, neck pain, numbness and tingling in her hands, and low back pain. This is a very common symptom pattern in torture and trauma survivors, and is not always improved by counseling. Sometimes it needs a more directly somatic intervention.

She presented as a small, thin, timid looking woman, who kept her head and eyes down during the initial visits, with occasional moments of fleeting eye contact. This fleeting contact revealed that Jana's eyes were bright and alert, and gave me the impression that she wanted to be where she was. She held herself tensely in the way previously described - sunken chest, hunched shoulders, head well forward on her shoulders and the back of the neck compressed, with little spontaneous head movement. Her breathing was shallow, and she moved as if she were trying not to make any impact on her surroundings.

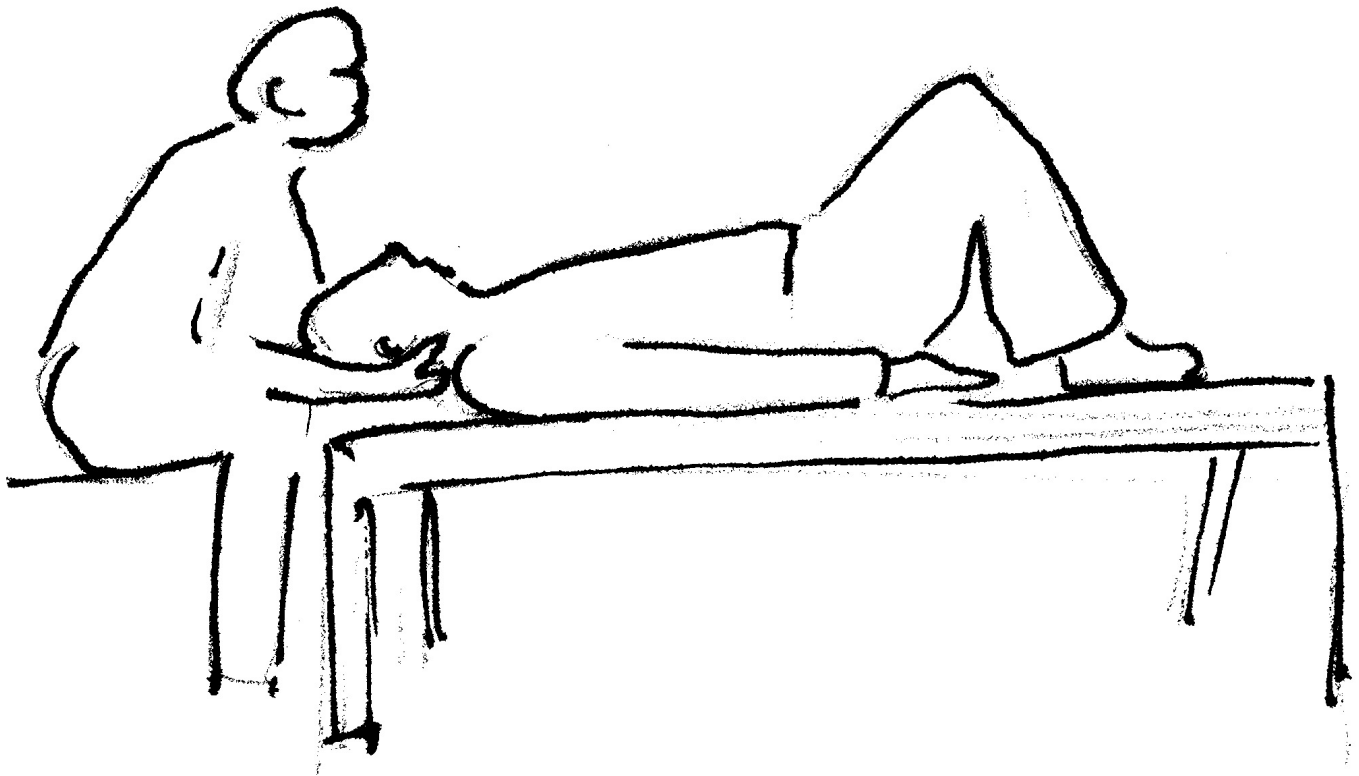
I was curious to explore whether her headaches were connected with the constant contraction of the muscles at the back of her neck - and the constant pulling of these muscles on their attachments at the back of the head, the shoulders and the mid back, but first I needed to explore the tissue of her head and neck to see if these had been injured, such as by repeated beating in a way that may be contributing to chronic head pain. (A CT scan had not revealed brain pathology). Her scalp and neck did not feel as if they had been subject to this trauma but the neck muscles, and the scalp, were tight, and the joints stiff. This initial exploration allowed me to discover how Jana felt about being touched in such an intimate way. She did not relax, but remained aware and present, and did not dissociate.

I next focused on facilitating Jana's neck muscles to lessen

their constant contraction, and to allow lengthening of her neck. Her headaches often felt less at the end of a session, due, I felt, to a slight relaxation effect, but sometimes her head felt 'heavier'. After a few sessions, I felt the muscles becoming more responsive to my hands, but when she sat up she was more bent over. This could be interpreted as Jana feeling more relaxed and therefore less protected and more vulnerable. On a musculoskeletal level, it could be interpreted as a lessening in the chronic contraction pattern resulting in insufficient muscular activity to keep Jana stable in an upright posture. She also reported that she felt 'strange', 'tired' and 'weak' for a number of days, though her head pain was less acute. She described experiencing out-of-body episodes that sounded like dissociation. Jana had difficulty describing and knowing her feelings.

Jana needed to learn, or relearn, a different way of organising her body - one that enabled her to feel stable and secure without resorting to the familiarity of her habitual tension pattern to provide that stability. The risk of relaxation in severely traumatised people is that of being overwhelmed by the sensations/thoughts which habitual physical tension prevents them from feeling. I wondered if this was happening to Jana and that she was dissociating as a result. ("Don't treat my tension - it's all that's holding me together" - Bumper sticker around in the 1980's.) I was anxious to avoid inadvertently encouraging dissociation in Jana by facilitating too sudden a change in her body and physical sensations. It seemed as if the more effective a session was in changing Jana's bodily organisation, the more likely she was to feel 'strange' and have episodes where she felt as though she was not present. Her dissociation was sometimes dangerous, such as having near misses with cars, and leaving the gas burning when she left the house.

I avoided this possible response by breaking down the lessons into shorter more easily digested lessons, and by asking for her constant verbal feedback, which demanded that she focus on the minutiae and the flow of her physical sensations. I wanted to know about how she felt, both in terms of what she sensed happening in her body and also whether she liked it or not. Jana had talked very little and became passive when touched, but gradually became more articulate, and far less passive as a result of this approach. I also used my hands to provide precise support and stability when needed - a function which her muscles had not yet learnt to do (except by being



constantly contracted in an undifferentiated way). Jana's sighs and deeper breathing indicated to me when my hands were successfully providing this support. (Illustration- hands under head)

Most of my work with Jana consisted of helping her to discover a stronger functional stability without resorting to her habitual and uncomfortable tension pattern. A large part of this work involved improving Jana's awareness of those parts of her body, which she had previously ignored, both through the imposed rigidity of her habitual pattern of organisation, and her lack of awareness of all parts of her body except those that cried out the loudest. For instance, discovering the movement available in her ribs and shoulder blades, and how it could be incorporated into the rest of her body movement, enabled Jana to begin to move out of the chronic contraction pattern in her neck and shoulders, and also to breathe more deeply. (illustration)

The pelvic area is a powerful source of strength and stability. Jana's pelvis was poorly differentiated from her spine - in other words, she tended to move her spine and pelvis in a block. This resulted in constant strain in her low back as her spine stretched and pulled against an un-moving heavy pelvis. She felt pain when bending down or putting on shoes - any activities that demand a mobile pelvis. However, Jana found great difficulty focusing on her pelvic area, and never managed to let go of the muscles of her belly to explore other ways of controlling her pelvis. When I tried to bring her attention to this area she became withdrawn, passive and inarticulate again. She never talked about her experiences in

the concentration camp, except her anxiety about being separated from her child, but I assume that the difficulty she had in moving her pelvis, compared with her willingness to explore the possibilities of movement in her upper body, was connected with these experiences. Due to the freer movement in the rest of her body, Jana was eventually able to move with less strain on her back, but her pelvis remained undifferentiated and her belly remained clenched.

After eight months, Jana was taking her analgesic medication only when she needed it, rather than several times a day. Her headaches were no longer constant, although occasionally just as severe. Her neck and shoulder pain was far less, and her hands symptom free. She still tended to sit hunched over, and hold herself tensely, but was capable of more spontaneous movement and felt more physically comfortable. She could do more, like put on her shoes and sit in class, with less pain. She looked and felt more relaxed and was sleeping better. Her memory was improving and she never missed appointments any more. As Jana felt more physically competent and capable, she began studying more, and, hoping to retrain and find work, started a full-time TAFE course. This meant she could no longer attend STARTTS and I no longer saw her.

Sue Roxon is a physiotherapist and Feldenkrais practitioner and has worked since 1994 at STARTTS.