THOMAS HÜBL

TRANSCRIPT

The Mystical Principles of Healing

PART 2

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Hilorie Baer: Welcome everybody. I want to say we're delighted and we're honored to have Dr. Peter Levine with us today in conversation and discussion with Thomas. Dr. Peter Levine has been a pioneer in the field of stress and trauma for over 40 years. He has a PhD in Medical Biophysics and a doctorate in Psychology. He is the developer of *Somatic Experiencing* and the founder of the Foundation for Human Enrichment as well as the author of the best-selling book *Waking the Tiger: Healing Trauma: The Innate Capacity to Transform Overwhelming Experiences*.

He has also co-published a comprehensive book on childhood trauma. He's the recipient of the 2010 Lifetime Achievement Award for the U.S. Association of Body Psychotherapy. His work has been widely trained and practiced throughout the world. I know many of you are familiar with him and his work, so we are super excited to have you here with us.

We're just going to start with an opening question to you, Peter—and then Thomas will come in—about what your definition of trauma is.

Peter Levine: The most widely accepted definition of trauma is trauma as PTSD, Post-Traumatic Stress Disorder. However, I use a much broader term. When I first started to develop my work, which was in the 1960's, there was no such definition. There would be another 15 years before the definition of PTSD—and I think it was 1981.

Again, the widely accepted definition of PTSD is a constellation of symptoms such as hypervigilance, always being on edge, always expecting danger; hyperactivity, being charged—like adrenaline charge; intrusive imagery, flashbacks; sleep disturbance and so forth. These are all what are called positive symptoms. I think also even now, people in the field realize that there are other symptoms like shutdown, depression, and a lack of ability to connect. Really, my biggest definition would be a significant inability to be in the here and now because of events that have accumulated over our lifetime.

Now, some people unfortunately, of course, experience what's sometimes called "Big T" trauma. These are things like rape, child abuse, war, natural disasters, and so forth. But the definition that I prefer is that trauma is about events that were overwhelming at that time in a person's life. There are many factors that determine that, of course. You don't necessarily have symptoms like PTSD symptoms but then, there are some things in your life that trigger you, that upset you: a certain type of voice maybe, even something as subtle as that, and you stiffen.

The person who has been sexually abused as a child, she may have no memory of it but then when her loving spouse touches her in a kind, gentle, sensuous way, she stiffens up or feels nausea, feels like throwing up. Sometimes, even accidents that children have had—like falls off of bicycles—this may leave the person with almost an apprehension about riding a bicycle, something so simple, or the opposite: like they become daredevils. Actually, I interviewed a number of people who did daredevil bicycle riding, this kind of extreme mountain biking, and many of them had bicycle accidents as children.

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This is a really, really wide, wide spectrum. The traumas that occur over our lifetime, over our developmental arc, they have very different effects. I prefer to use post-traumatic stress—oh God, what's the word? I forgot. Post-traumatic stress—and these stresses can be from single events or from the accumulation of stress over the lifetime of the person. They can add up and then, all of a sudden, something happens. And it could be relatively minor, or it could be something extreme such as war trauma. Then, all of a sudden, things just fall apart.

Now, I remember it—post-traumatic stress *injury.* Because it is an injury. It is a wound. It is the invisible wound.

Again, trauma can just rob a person of their capacity to engage, to be in the present, to live without constant fear or depression. Again, it can utterly destroy a person or it can just linger there. For example, people—I work with a number of people who were in the Holocaust, and then children of those people, and then children of those children. We'll maybe talk about that later.

Obviously, that's a devastating, horrendous trauma.

You find that people who have had that experience tend to fall in two broad categories: one is that they are completely disabled, barely able to function; and the other is that they appear to be functioning very highly. Many of these people were extremely successful in business, they had families.

However, let me give one example. There was a woman who worked in a dress manufacturing company. One day, somebody, I think, threw a cigarette into a trash basket and it began to smolder. Somebody noticed that and they put it out right away. However, the next day, this woman couldn't come to work. And then after that, she could barely go anywhere outside of her immediate neighborhood. Then finally, she found herself virtually homebound and I worked with her in her home.

What is all this about? If you knew her history, it would be clear, right? Up to this point, it's a mystery. Why in the world? I mean, if it had started a fire and people were really in danger, but it was just a little smoldering and it was immediately put out. Well, this woman was a Holocaust survivor, and the smell of the smoke triggered her response to when she smelled the smoke from the ovens.

These things, they lay dormant until something activates them. There's been a lot of research on people who have developed war trauma. One of the things that they're saying is that these people very frequently had earlier childhood trauma. That's a no-brainer because if you do have early childhood trauma, you are more susceptible to later trauma. That doesn't mean that that event that triggered it was trivial—just contrary, au contraire.

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So, as you see, trauma is such a wide phenomenon. I would say that it really stays at the core, at the epicenter, of human experience. If you look at the great writings of the Greeks—*Homer*, *The Odyssey* and *The Iliad*—that's about trauma. The Egyptians, the Sumerians wrote about trauma. They didn't call it trauma.

I've had the lovely opportunity to spend some time with different shamans, mostly in South America. We do have a training program in Brazil. They have a term called *sustos* in Spanish; *shustos* in Portuguese and it literally means fright paralysis or soul loss. That's really a much more accurate description of trauma. Fright paralysis: the deer in the headlight; frozen; unable to move; overwhelmed; the feeling that we've lost this core part of ourselves; this connection to our spirit, to our soul. That is, I believe, the essence of trauma. That was your question of what is my definition of trauma. I hope I didn't go on too long.

Thomas: No, the opposite, it's a—so thank you very much and a very warm welcome also from my side here and it's very interesting.

Maybe because you mentioned before the development and the time—like the trauma can hit us in different times of our development and I find this personally very interesting—maybe you can expand a little more on how, or in your rich experience, are there differences when a trauma hits us very early or an impact hits us a little later in our development or when we are grown up? And maybe, what's the term resilience in this regard? Maybe let's hear a little bit about that.

Peter: Yes. This is a very good question, a very important question. When the definition of PTSD came out, it was pretty well-assumed only adults—and only adults who were exposed to war and rape and things like that—could develop PTSD. Certainly, a young child couldn't, a baby couldn't develop PTSD. You can't ask the person, "Are you having flashbacks?" But if you look at their reactivity, you see that this goes back from intrauterine, from the fetal environment where there's a high amount of stress, and this is usually—not always—often caused by the mother stress or the stress that's in the field of the family.

This goes through via stress hormone release as well as direct neurogenic effects when the mother is in a state of prolonged or chronic stress. Usually, if there's a relatively minor trauma that occurs, that doesn't have that kind of adverse effect. But ongoing stress and trauma really affects the fetus in a way.

The nervous system of the fetus, the brain of the fetus, it's a very diffuse network of neurons compared to an adult. Also, there is very little inhibitory neurons. Neurons are either excitatory or inhibitory. The inhibitory neurons develop much later than the excitatory. So if you overstimulate the brain of a fetus, the activity of that brain goes up very, very high in the core parts of the brain. It goes up very, very high and it stays high and only very slowly comes down.

We call this in *Somatic Experiencing* 'global high activation.' And you see many people with trauma, the primary thing that they present with is that, when they are upset they cannot come down. They cannot regulate themselves. The early stresses, fetal stresses also, I believe—and maybe we'll talk about this later—are the nexus in which generational trauma is passed on. It's passed on from generation to generation. I believe that happens fetally.

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My personal belief is that trauma goes back even earlier than this, perhaps even to the moment of conception. I have some empirical data about that, as do a number of my students and other people. But, let's just say that the nervous system—the effect begins around the second trimester, at the end of the second trimester when the nervous system is—there you have the predisposing factor to make the nervous system over reactive.

The birth process itself, of course, can be traumatic. In birth, and particularly in hospital births, of course, they monitor very carefully the heartbeat. If the fetus is under stress, the first thing that happens, usually, is the heart rate will go up. Then sometimes you get a very sharp drop in the heart rate and it goes very low and that's the time—and it's debatable when intervention should occur—but that's what tells the obstetrician that they may need to do a cesarean.

This is important because my understanding of trauma has shown me that there are two primary features of trauma: one is the hyper-aroused state; and the other is the shutdown state. What I'm talking about here is shutdown state. That is much less visible unless you really know what to look for. But you see people who have this basic pervasive apathy. The term that sometimes is used is alexithymia—just a lack of feeling, a lack of ability to feel and to connect.

Then you have the birth process which, again, can be traumatic. By enlarge, if the infant then is allowed to connect with the mother and held by the mother, that tends to help regulate that early dysregulation that was caused by the birth process itself. Again, because you don't have symptoms of PTSD, maybe we shouldn't call it 'birth trauma' but 'birth stress,' extreme birth stress.

Now also this period shortly after birth, for the next several months, is about a critical developmental process or sequence which is about bonding and attaching. Very often, when babies aren't attached, it's seen that the mother is unable to provide enough of that environment. And this is sort of a revision of the—can be a revision of the 'blame it on the mother.'

I have, for example, in my book *Trauma and Memory: Brain and Body in a Search for the Living Past*, I demonstrate a couple of sessions that I've done with a series of photographs. I was working with this 14-month-old. He was having physical problems. He had reflux and they were afraid it might go back into his lungs, and they wanted to do an endoscope which is a—and his birth was extremely traumatic. He was breach and his head was wedged into the apex of the uterus. They had to perform an emergency cesarean. Even then, they couldn't get him out because he was so much wedged in. They had to use suction to pull his head out. His mother, you could see, was a very caring mother, a very present mother, a loving mother.

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When they came in, she would spin him around to soothe him rather than gently rocking him because his nervous system, you could see, lacked the responsivity. They never attached. He might come to her but then he would go off and do autonomous things. When we renegotiated—and as again, I describe in the book how I did it—when we renegotiated the trauma, for the first time, he crawled up into her lap and put his head into the curve of her shoulders and just tears came out of her face, out of her eyes. She said, "Oh, darling. Oh, darling. He's never done this before. I've never seen him cry. I've never seen him be still."

Again, the trauma separated both of them. And until they were able to renegotiate that together, the attachment process, the bonding process was unable to complete. What's miraculous is that this can happen not only 14 months after an event, but 14 years, 24 years, 34, 45. I've worked with people in their 90s where they've renegotiated different kinds of trauma, including early trauma.

The trick here is to understand that trauma is not in the event. It's what goes on in the nervous system and the body: the brain, the nervous system, and the body and that's critical. That's what's been missing in our understanding of trauma, universally. Although I've been doing this work for well over 40 years, it's just recently now that this is starting to be accepted broadly. One of my colleagues and I have discussed and written about this for years and years and years, Bessel van der Kolk, who's written an excellent book also on the subject, *Body Keeps Score.*

Trauma is something primarily that happens in the body. When our body stiffens, our bodies retract, our bodies collapse in the face of threat. What happens in trauma is this gets stuck in the body. What happens in the body doesn't get to unhappen; it stays there and that's the miracle of being able to work through the body. It's because when you can change what the body has done, then you are creating new experiences, experiences that contradict those of overwhelming helplessness. That's the key to successful trauma therapy. It's not to relive the trauma, it's not to try and erase the trauma. It's to be able to revisit the trauma and engage new experiences, opposite experiences.

The person who I studied quite extensively was a person who won one of the early Nobel Prizes in the early 1800's, Sir Charles Sherrington. He was a—not a colleague, but they worked around the same time—he and Pavlov. He showed that in the nervous system you have basically excitatory and inhibitory systems, and that when one action is happening, it inhibits another action from happening.

For example, if I take my hand and bring it towards my face, I'm contracting the biceps muscle. If I reach my hand out, I'm contracting the triceps muscle. The nervous system is wired so that when I bring something towards me, the triceps are inhibited and vice versa; otherwise, you'd be going like this *[demonstrates his arm being unable to either contract or relax fully, creating a shaking motion].* You wouldn't any smooth shift. This is a universal part of the architecture of the nervous system. When we have experiences of goodness, of wholeness, then that contradicts the trauma.

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I hope it's okay to mention, in my book which is my main book called *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness*—what I'm talking about is how these things change, how these experiences change in the body. And how that's what—no, I was going to say what neutralizes the trauma—but which makes the trauma be able to be transformed into something rich, into something good, into goodness.

That's why, again, in that title, *In an Unspoken Voice: How the Body Releases Trauma and Restores Goodness,* when they published it in Germany and other European languages, that word didn't make sense. So it said *How the Body Establishes Inner Regulation,* but I'm talking about goodness more in the Buddhistic sense. I know from your website that you are clearly interested in things like this.

Again, many of the things that I do in *SE,* in *Somatic Experiencing*, these are things that different traditional spiritual practices have done. Particularly I've noticed this in some of the Tibetan Buddhist practices and in the mystical psychology, the spiritual psychology, developed in India, for example; the energy systems, the chakra systems. There's a lot of overlap. Of course, people—because trauma has been with us forever—these different spiritual traditions, I think to a significant degree, were ways that people found to help people move through trauma, to not get stuck in trauma.

Some of my deepest studies, you mentioned my degrees, but my deep interest and what really informed my work more than anything else was the study of animals in their natural environments. I realized, of course, that animals—prey animals—are threatened on a routine basis, every day. There is some predator that's lurking behind the bushes, potentially. Yet animals in the wild, from my studies at least in my interviews with people who are wildlife managers, animals in the wild don't experience trauma from these predation events. They somehow shake it off.

I realized that since trauma affected the same parts of our brain and our nervous system for animals and humans—they are virtually identical, except we have a bigger frontal brain—that somehow we were interfering with what gave the animals a natural immunity, a resilience if you like. Then I found that this resilience is innate; it lives within all of us. The question is how do we tap into it? The very sensations that take us out of trauma and build resilience, traumatized people are frightened of those very same body sensations.

Now, in *Somatic Experience,* we gradually reintroduce people to those sensations so that they can shift. I call it titration: we do it one small amount at a time, so we don't expose the person to the whole trauma. Because in terms of the nervous system, if the nervous system is overwhelmed, it doesn't distinguish between that overwhelm and the trauma that may have occurred years ago. It's really critical that we take this a little bit at a time in working with traumatic memories. Again, that was my main thesis in the book, *Trauma and Memory.*

I think there's one other thing I wanted to say about this…ah, yes.

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What very frequently happens when people are renegotiating, is the term I use, their trauma is that certain responses that people use to defend themselves which were overwhelmed—that those defensive responses reassert themselves. I'll give a personal example. Actually, it's the way I start in *An Unspoken Voice.* I was walking across a crosswalk in the beautiful Southern California morning, and a car went through a stop sign and hit me. I was thrown up into the windshield and then out onto the road. Fortunately, a woman came and she announced herself as a physician, a pediatrician actually. I remember thinking, "Oh, that's exactly the specialty I need right now." She said, "Is there anything I can do to help?" and I said, "Yes, please just stay here with me."

She took my hand in hers, and that connection, that sense of enough safety allowed me to move through all of the physical sensations and undo my trauma, so that when I was in the ambulance there was no trauma and they were shocked because my heart rate was normal, my blood pressure was normal.

One of the things that happened is I felt my—while she was there with me, I felt from inside of me—my hand starting to come up to protect my head from the windshield. Then I was thrown in the air, my other arm reached out to protect my head again from hitting the pavement, the road.

I remember then feeling waves of energy, including rage at the teenager that hit me, but waves also of gratitude. I think that's one of the side effects, spiritual side effects, of renegotiating trauma, of healing trauma is it really brings us to a connection not just with ourselves but with others and with humanity. I think two things unite us more than anything else with people throughout the world. One is music, and the other is trauma.

Thomas: Wow. That's so rich. There are so many things that come up in me while I listen to you so thank you very much. Maybe a last—there's so many—this was so rich I need to see.....

The last question according to the developmental aspect; did you find in your work that, for example, if you work with somebody on a perinatal trauma or a trauma that happened with two years or with 16 years that there is a difference in the work that you experience? And what is that difference, if so?

Peter: All right. Thank you for re-bringing that up. Sometimes, of course, I'm working with the baby, with the child, with the toddler, with the adolescent at the time of the trauma. At other times, I don't get to see the person until many, many years later. And the thing about trauma and development is that trauma very frequently—real trauma always interferes—but it can interfere significantly with what goes on in that development.

When I was talking about the baby that I worked with, the 14-month-old, he was unable to attach which is a normal developmental phase for babies, because of the trauma. So, what happens if a baby has a fall and nobody notices it and the baby is crying endlessly for an hour and then shuts down? The process of attachment then becomes limited.

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When the toddler begins to walk for example, an 18-month-old, and that's a powerful, unbelievable part of child development because for the first time—hopefully, there's a been a secure attachment—the toddler is now venturing out into the world, is leaving the safe base of the parent or parents and now is exploring. This is the time when the dopamine system is coming online in the brain, in the nervous system. You see two-year-olds and they're just, "Gaaahhh!" I call this the stage of 'world be my oyster.'

What happens if the child experiences a trauma there? It could be a significant trauma or even the trauma of the parent, and this does happen very frequently, for example, the mother because the early stages of symbiosis, of this intimate connection the—let's just give the example of the mother but it could be all parents—when the child starts to separate, the parent feels real insecure and inhibits their exploration.

But, let's just say the child is exploring and it's very likely they'll get hurt because they're into everything. The child that goes into the plate glass or falls off the table—this can affect their capacity to explore, to initiate, and to explore things as adults or can have the opposite effect where you see people who are counterphobic and are constantly looking for danger.

Similar applies to the five, six, seven, eight-year-old when it's about gender identification. It's not flirtation; it's a playfulness, a playful flirtation, not in the sexual sense, but of the practicing sense of children being together and noticing that there are differences between boys and girls and being curious about that.

Then in adolescence, if there's a trauma—and around three, four, and five years old—shaming, excessive shaming, can be a tremendous trauma. Adolescence, again, shaming is very potent traumatogenic process. Again, we go on and on, but those are the main stages of development that take us towards the twenties and then into adulthood and then into aging.

Again, talking about these hidden trauma, one of my students was working with a woman, and this woman was diagnosed as being paranoid. And she was. She was afraid that people were out to hurt her. She just, again, could not leave the house. She had been in the Holocaust and paranoia was a normal response to an abnormal situation. So, shame is a very important component of trauma.

It's interesting because the physiology of shame—and I'm talking about repetitive shame or humiliating a child, or an adolescent, or even an adult—that results in the same kind of collapse and withdrawal of one's energy and losing of one's spirit. Again, shaming usually comes in the context of relationship and so an important thing when you're working with people with toxic shame—what John Bradshaw called toxic shame—you need to work with it in the relationship, when there's trauma.

But the relationship itself cannot heal the shame. One needs to work both with the trauma and with the relationship to heal shame/trauma.

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Thomas: One question that comes up in me is when you said before like a big part of your studies was on animals, and you found a natural resilience. And then you said, it's about us tapping into resilience. So, can you expand a little more? How can a person basically tap into higher resilience? We'll talk later about the collective aspect of that.

Peter: There's been a lot of discussion, a lot of published papers now on resilience. I would say whenever we work with a person, whenever we work with a traumatized person in *SE, Somatic Experiencing,* that is about restoring resiliency, like with the animals.

Indeed, when an animal escapes predation, not only does it need not to be traumatized because then it's going to be scooped up for lunch the next time, but it needs to actually get even more of an edge because you think about predator-prey encounters—it's a Darwinian, Olympic race. If you escape, you win the gold medal. But there is no bronze or even a silver medal. You either escape or you don't. If you do escape you want to be able to actually have more capacity to escape from future predations.

I saw this wonderful—I think it was National Geographic—I have not been able to locate it. But these three cheetah cubs were chased by a lion and they escape by climbing up a tree and finally, the lion gave up and then went off and the cheetahs climbed down from the tree and the three of them practiced, they had turns. One of them would be the lion and would chase the other two, and then then the next, and then the next.

They were learning to be more effective escape—to develop more effective escape. To me, resilience is this core nervous system response as well as developing the things that were lost, that were taken away from us when we were traumatized. To me, successful renegotiation of trauma is equivalent to increasing one's resilience, one's capacity to rebound, and to be prepared to deal with other events, other potentially threatening events, later in our lives.

Again, resilience, sometimes people talk about it as people's ability to be more aware of their thoughts and so forth, and that can be important. When you have constant negative self-talk going on in your head that erodes the person's ability. That diminishes their resilience. But, I look at what I call core resilience, which again is the autonomic nervous system, the involuntary nervous system's ability to go into states of hyperarousal or hypoarousal, shutdown, to be able to regulate itself.

Every time that happens, the autonomic nervous system itself becomes more resilient. These colleagues and I published an article basically on this, what we called *The Core Response Network.* You can get it; it's at *Frontiers.*

Again, this is something that, I think, has been missed in psychology and in trauma therapies: that really what it's about is helping people have new experiences that contradict those of overwhelming helplessness and to increase the person's resilience, their capacity of resilience by working through these different traumatic events. Or even actually—sometimes you are working with the event, with the memory, but other times you're just working with the effect that that had on the body.

Again every time that you can actually—instead of going into hyperarousal and getting stuck there—you go into hyperarousal and then come down, then you're autonomic nervous system becomes more resilient and *you* become more resilient because this is about bottom-up rather than top-down.

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The cognitive approaches, for example, to trauma have to do with trying to change your thoughts, to be aware of your thoughts. That can be of some help, but there's no way you're going to get at the essence of trauma, at the core of the trauma. That has to come from inside, from the body, from the nervous system. That's what I call bottom-up processing or bottom-up effects.

Thomas: How do you see the nervous system of the therapist in establishing or re-establishing a relation to the client? Can you talk a little bit about what you found in your research about two nervous systems communicating?

Peter: Yes. It's been very clear. A lot of research about this, and Dan Siegel has written some really good books about that. Our nervous systems are designed to co-participate right from the moment of the birth when the baby is held, when the baby has a first smile or opens their eyes for the first time. Then that dance is going on, that magical dance.

And so are nervous systems are not designed to operate in isolation. We are one part, one half of a participatory nervous system. Given that, we have this very deep capacity to help people co-regulate. That's what the woman did, the pediatrician, who came to my side when I was hit by the car. She allowed our nervous systems to participate, to co-participate.

Now, when you're working with traumatized people, particularly people who are in the shutdown state, you can't just get in a participatory relationship. So some very interesting research that came from Ruth Lanius' laboratory—she's probably got the most sophisticated brain scan, probably in the world. She showed a picture of a friendly face to a normal healthy subject. When she did that, you could see the frontal part, the medial prefrontal cortex, increased in its metabolic activity.

However, if you show that same picture to a traumatized person, the area in the brainstem, their core part of the brain—the autonomic nervous system—that core part of the brain got activated; that has to do with paralysis and fright. Even a friendly face caused this shutdown.

Very often when I work with clients, in the way we teach often in our trainings, is I often have my chair at a 45-degree angle with the client so that if they want to engage with eye contact, they can; if they want to not do that, they can. It also has to do with that, I am here, but your work is within you. And I am here. With trauma, it's not just a matter of our nervous systems co-participating because that can actually, as I just gave in this example, can actually cause more shutdown, more dysfunction.

Generally, when people go from the state of shutdown they move into the state of hyperarousal and then the therapist can help bring them back and bring the nervous system to baseline, again, with higher resilience. That's when the client really seeks eye contact, wants to be in connection, wants to talk, and it's not just with humans. You see exactly the same thing, for example, with many mammals.

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I had a wonderful experience a few years ago being invited by this horse whisperer, I mean this man was for real, a real horse whisperer. And he had read *Waking the Tiger* and was very excited because he realized that he was doing many of the same kinds of things with the horses. He had a horse that was really spooked, and that horse was—we were in a corral—and that horse was way, way, way on the far part of the corral. We were all, I think, there were four of us with three horses over on the other side.

So, Buddy went to be with that, the spooked horse, the traumatized horse. He just very slightly—had a stick with a little flag on it—and he moved the flag to the point where he could see the horse begin to react. And then that was it. Then he stayed and calmed the horse just the way I was just describing with a client. And I had to laugh, because that's one of the techniques that we use, that people learn in the third of the year the training program.

After he had worked with the horse, that's it, he just came back where we were and within a few seconds, the horse came over and joined our little clutch over there with the four of us and the three other horses. So it was now four horses. The horse now, as he resolved some of the trauma, wanted the contact. This is again, this is a mammalian function, a mammalian characteristic and so is our urge, our drive to connect, but trauma interferes with that.

Thomas: If we maybe explained a little more, because I live currently in Israel, and we did a lot of work between Germany and Israel on the Holocaust past. I'm interested basically in two things. One, you mentioned it before a bit but I would love you to expand a little more on the transgenerational trauma, second-generation, third-generation what's your experience in the transgenerational line?

Then I'm also interested maybe as a second question afterwards, how do you see in cultures that are living like, for example, in Israel that are living in, let's say, crisis or hot zones and there are—like two years ago, there was the war in Israel—and I found it very interesting the dynamics in the cultural fabric. I would love, first, the transgenerational trauma and maybe later, if there is still enough time, to look at also what are actually cultural—are there cultural trauma agreements that are part of the cultural fabric? That's something that I'm very much interested in.

Peter: Let me try to actually hold those together and talk a little bit about them together. A number of years before the last intifada, so that was quite some time ago, I was doing a training program in Jerusalem, and we also were able to get a number of Palestinian therapists there as well from Gaza Mental Health and from West Bank. I had been talking about—somebody asked, "Don't you have to know what the trauma is to be able to work with it?" And I said, "No, because the imprint of it is in the body. So you don't need to know." I said, "If somebody wants to volunteer if they've had a symptom, that's all we need, then we can work with that."

This man—and I know it's okay to mention his name because he's allowed this to be in public, I don't know if he's still alive—Haim Dasberg, and he pioneered psychoanalytic work with Holocaust survivors. He had been having this severe back pain for 30 years, unremitting back pain. And so I said, "Certainly, come on up here." I had him become aware of the tension that was underneath the pain.

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As he did this, I think I said something like, "Is it the same on both sides or is it more on one or the other?" I think he said, "It's more on the right." I said, "Okay, so just noticing what that tension very, very slightly might want to do." And then he found his body starting to twist and then sweat started to come in there from out of his face and literally actually even down onto the floor. He felt himself falling backwards, and I put my hand behind his head as support.

And then he was back where he had been ambushed. He was an Army doctor, Army medic, and they had been ambushed and he saw, you know, these horrible, horrible, horrible things. He escaped because he fell off the truck onto his back in a ditch. When he finished, and again you could see waves of cold and warmth and shaking and trembling, and then he opened his eyes and he looked around. He looked at me and he looked at the other people—the social engagement system. I could see that people were very, very deeply moved. As I often do, I allow a little time for people to share some of what they experienced while they were observing.

Some people shared and this one woman from Gaza Mental Health, I remember, she just had such an amazing presence, and tall. I remember she was wearing a gray flannel suit, and she got up and she said, "Haim, when you came up to work with Dr. Levine, I prayed that something terrible would happen, that you would be re-traumatized so you could know what your people have done to my people. But, as I saw your work—I can't explain it—but I felt something shift within myself. And I realized, Haim, until we heal ourselves, we will never be able to heal our collective trauma, that until we work with our own trauma, we will continue to reenact this trauma."

You see it not just in the Middle East but in so many different places, and you can see things are driven by trauma. When things are driven by trauma, you are unable to make differentiated judgment. You're unable to say, "Maybe what we are doing here by preventing you from going about your business, maybe that gives you a legitimate gripe."

And the other side can maybe say, "Yes. When we really don't put more effort into stopping people from doing these things to your people, like putting bombs on buses and things like that, we are just reenacting your trauma." There's not a nuance that is able to say, "Wait a minute. We have to get together on this." And I don't believe that'll happen, I'm sure that that can't happen, while people still are in these traumatically based things.

Gina, one of my students, has been doing a tremendous amount of work in the Middle East and helping the children, I think, both in Israel and Palestine to not be traumatized. Because when they grow up, they are going to immediately continue that intra-country violence. In order for that to really shift, this fundamental thing that we've been talking about today, really does need to shift.

Now, this brings me again now to—about generational trauma and to generational transmission, not *just* a trauma. I've worked with using this example—and I hope I'm not overdoing it, but there's a reason for doing that—this one person that I was working with in a session she smelled burning flesh, and she experienced nausea, which was interesting for a number reasons.

[01:00:00]

First of all, where did that come from? Second of all, she, and a number of people who had these kinds of reactions, were vegetarians. They probably never even smelled meat. As I started to ask more questions, these people had parents, or even grandparents, that were in the Holocaust, and I couldn't explain that.

When I first wrote *Waking the Tiger,* I had a chapter, that was, *How Far in Space and Time?* I was criticized for saying things like this because it really seemed outlandish—that this was just some kind of a fantasy that I had—but I was coming from clinical observations. Anyhow, I came across recently in writing *Trauma and Memory*, because chapter nine is about generational trauma and generational transmission of knowledge, there was an experiment that was done with mice.

They exposed mice to a very pleasant or neutral scent of cherry blossom, and they seemed to be interested in it. Who knows if a mouse is actually enjoying something or not, they're just going about their business. Then if they presented this smell and then gave the animal a shock on its feet, after a certain number of pairings, a couple weeks later, if you just gave them the smell they would freeze in fear and defecate in fear. That's no surprise; that's just a Pavlovian conditioned reflex, conditioned response.

However, what was interesting is when the mice bred and they actually went back to five generations—so the great, great, great, great, great, great grandchildren of these mice that were exposed to the smell and the shock—as soon as they were given this smell, just the smell, they were never shocked, they froze in fear and defecated in fear. The memory, the specific memory, was transmitted from generation to generation.

Think of what happens if there's a war or domestic violence how these things tend to repeat, tend to go in cycles. I thought, "Wait a minute. What's the advantage of transmitting trauma from generation to generation?" It's just doesn't makes sense. Why would we be doing this?

Then I recalled a couple of things.

When we worked in Southeast Asia after that enormous tsunami many years ago, I guess ten years ago, one of the things that people told us is that right when there was the earthquake, the elephants and other animals scurried up the hills and got out of the way. Then some of the people knew to run but particularly those who were in—so-called "primitive" tribal people *[Peter indicates quotes with his fingers].* As soon as that happened, they scurried to higher ground.

How did they know to do that? Because the last event before this was 300 years, yet these people and the animals knew immediately. Now, you could say, "Maybe they retold those stories over and over, again." Well, that's possible. But it's also at least as possible, at *least* as possible, that this was somehow in their DNA.

By the way, this does affect our DNA through what's called the epigene. These are the proteins that go on the DNA. And say which genes are expressed and which genes are repressed. It's a whole new field now. It's really amazing and it's really showing that what we used to think of as genetic is at least as much environmental.

[01:05:00]

Anyhow, so there was that.

And then there was—I remember working with this one woman when I was living in Colorado. There was a plane crash, United flight 232. It was going from Denver to Chicago, and there was an explosion that cut off all of the hydraulic power. It was virtually impossible to control the plane. Captain Al Haynes, he was the pilot, and then there was this other man who actually was a pilot who trained people in emergency disaster, so he came up and the two of them tried to get some control by bearing the thrust of the engines.

The plane crash landed in a field in Iowa. Basically, there was a runway right near a cornfield. The plane broke up and exploded in different fireballs. Miraculously, many people survived; many people, of course, didn't survive. I was working with one of the people who was on that flight. As we worked through the procedural memories, the body memories—and again, that's what I talk about in the book, *Trauma and Memory*, how to work with those physical body memories—she experienced herself crawling through the crushed fuselage.

She saw a very small point of light because the fuselage was crushed, and she went towards that light. And then the body memory that she had is sitting in the cornfield feeling the sun on her back. Then at the end of the session, after that memory, she remembered that both her father and her grandfather were in plane crashes, one commercial, one military, and they escaped the fireball by crawling to the light.

She knew immediately, because she was upside down, to let herself down and to crawl towards that pin of light. You could say, "Maybe her parents told her about that." Of course, maybe. But the fact that that happened in this moment—because you're very unlikely to have a memory of sitting around the dining table and being told a story like that when you're in a situation of life or death. You do what your body prompts you to do. And her body prompted her to crawl and go to that light.

Again, with both father and grandfather, they escaped dying in fireballs in their crashes. I think that this really has to do with this—it's not just trauma that's transmitted, but the songs of our fathers are transmitted.

Thomas: I have one more question maybe to finalize this part. First of all, thank you. That's very interesting and also the vivid experiences of your own practice. I think it's very, very supportive and helpful.

So you mentioned before at the beginning of your presentation, the power of the spiritual practice. And I would love to hear a little bit more how you see spirituality, spiritual practice, presence, inner alignment, healthy self-contact, and also healthy relational contact as a resource, both for the client and also for the therapist, maybe.

Peter: That's right. Spiritual practices and religious practices can be very important in people's lives. I work with people who should have been highly traumatized. I remember working with this one man right after there's a big earthquake in Greece and Turkey. I was working with this Turkish man who was in the hospital bed. He had lost an arm and a leg. I talked with him and I remember him saying—and he just had this equanimity about him—and he said, "It is Allah's will." I'm not saying that he wasn't traumatized, but I'm saying his religion had some very positive effect.

[01:10:00]

The other side of this is when people work in this way, through the body, that routinely people have experiences that are more understood as spiritual experiences than as trauma experiences. Again, *In an Unspoken Voice*, the restoring of goodness, these very positive experiences. So, you develop spiritual types of experiences. Also the energy that is released in trauma, it's a very profound energy. If you compare that with some of the Eastern practices, the chakra practices, that's the first chakra, the root chakra.

In the spiritual practices, you cultivate bringing that energy up from the root into the "upper" centers *[Peter indicates quotes with his fingers].* To me, trauma and spirituality are two sides of a same coin; they really are very closely—now, that's also, that's not also about practice. Because just having a spiritual experience doesn't mean that you're all of a sudden, whatever it is, transformed spiritually. One has to develop a practice for this, of course. Very frequently, people after they experience *SE Therapy,* and the therapist, develop a meditative, a spiritual practice.

One thing I'll just add to that is that very often people who are attracted to meditation and spiritual practices are highly traumatized. The problem is that when you close your eyes to meditate you're going to either go into the trauma or dissociate away from the trauma. One of the people—and I believe he still does this, is very, very well-known and respected figure in the area of mindfulness meditation—is Jack Kornfield.

For the people who were in his teacher's trainings, he required them to at least take the first year of our training, so they would have some way to help guide people when they hit their trauma events. The key here is, I would say, embodied spirituality, because sometimes people have these wonderful great mystical experiences but then nothing really changes.

Thomas: Right. I very much agree with everything you said right now. So it's beautiful. Do you see also, for example, did you have some experience in your work for sure, I guess, like the edge of psychotic experiences—highly mystical or spiritual experience, and the trauma impact of psychosis? For example, once, you know, we are out of the psychosis but basically it has a huge impact, maybe, on our inner practice.

Peter: If you could condense, what would be the main thing you would want me to respond to?

Thomas: The main thing is what is the trauma, let's say, that maybe you have worked with that is a result of people going into psychotic episodes or—?

Peter: Okay. I'll tell you psychotic states are interesting. I don't have a lot of experience in working with psychotic states. But, you know, it's been said that the psychotic drowns in these experiences, the mystic can swim in these experiences.

I had the opportunity, at the Nevada Institute for Mental Health, which is a psychiatric facility. One of the psychiatrists—I had given a grand rounds there about my work, this was in, I think, 1982—he asked me to work with one of the psychotic patients because they were all psychotic. This was a catatonic schizophrenic and he had been in a catatonic state for now, I think, three years. They would bring him into this room where they had a one-way mirror so they could watch what I was doing. I didn't know what I would be doing, for sure.

[01:15:00]

Anyhow, the first time, I just came in and sat at the very end of the room. A couple of days later, I went a little bit closer, and gradually came within a couple of meters of him and sat by his side, not in front, because remember I don't want to create more shutdown. I started to tell him about what animals do to come out of trauma: the way they shake and tremble and have these spontaneous breaths and so forth.

I reassured him that if this happened to him that the psychiatrist, unless he was in danger to himself or somebody else, would not put him in a straitjacket or give him additional antipsychotic medication. After that session, about two hours later, he started to shake and tremble, and then was able to actually talk to the staff. And a couple of months later he was discharged to live in what's called a transition home, a halfway home.

So, the catatonia was the shock response and, as he was able to get support to move through that, he was able to—I'm not saying it cured his psychosis—but he was able to begin to live a life. Those are the two main things I would say about drowning in this kind of archetypal material, or learning to swim in this archetypal material

Thomas: Beautiful. Would you say that your own work, like your own inner practice or also your own spiritual practice—you mentioned Buddhism, for example—how is this a source or a resource for your own development of your own work and the whole body of your work? Do you see a connection there? Do you feel, I mean for sure, but—

Peter: Right. A little story. I was flying to give a lecture in Toronto on trauma and spirituality. That's why—I was living in the Bay Area in that time, in Berkeley. I was at the airport and there was a flight delay and another flight delay, and we didn't leave until after midnight. I was in the airport for four hours. Anyhow, we finally took off. As we were maybe 30 minutes from Toronto, the pilot announced that the ailerons were not working.

I remember looking around and people were crying and screaming. Other people, it's like they never heard it, they were just dissociated. Then the pilot went on to say that this is a condition that they are trained to manage, however when we would land, we would land very, very rapidly; it would be very fast. Also, there would be a whole line of emergency, fire trucks and ambulances, but that was just in case that there was the need for it.

I'm thinking, "I don't want to die in this terrified state." But nothing I could do was changing that. Then I realized I had an iPod, that actually, that Bessel had downloaded a bunch of his music, and there was some wonderful cello music on it, really fantastic. So I said, "Okay, at least I'll distract myself." I put in the earbuds and started listening, and the music transported me.

I was able to move through the terror. And then as I looked down, I saw all of these lights flashing and I thought, "Oh!" Because this was in November, I said, "Oh! They must be welcoming us to Christmas!" I was seeing these as Christmas lights and I just opened to the great meaning of Christmas and of the Virgin—of the Mother Mary and of the Christ figure. And we landed. And we landed fast. But I was deeply contained within myself.

And, that night, I slept—well, the hour or two before I had to wake up—I slept reasonably well; I don't always. I did have to do some work with it later, but I was fine. I was able to easily function.

[01:20:00]

I think there's at least an example of how we can take that edge, whether we're stuck in terror—you know there are two words: 'terror' same root as 'terrific,' same Latin roots. Similar: 'awe' and 'awful.' These are two experience states that are in a close relationship, and I think this was understood in some way for hundreds and thousands of years.

Thomas: Beautiful. Thank you for sharing that. That's deeply moving. Thank you. I'm aware of us reaching almost 90 minutes. Is there anything that you would like, from your side, give to the participants of this course? There are many health professionals, therapists….

Peter: Absolutely. I would say to health professionals and to everybody who's had trauma, I would say trauma is a fact of life, but it does not have to be a life sentence. That trauma transformed is a great gift from the gods taking us to presence, connection, and wholeness, and that this is an open possibility, a gift that can be conferred in the transformation of traumatic experience.

Thomas: Beautiful. Thank you so much. I think it was a very rich conversation. I could go on for hours because it's so interesting to listen and to learn from your deep life experience wisdom. Thank you very much. I think I'm speaking also in the name of many people who are listening right now.

Peter: Right, and people all over the world, right?

Thomas: Right, people all over the world, yes. I'm very grateful for your work and the contribution that you made to our understanding of trauma. I'm deeply grateful for your work so thank you very much.

Peter: Okay, my pleasure.

Thomas: Thank you.

Hilorie: Thank you so much, Dr. Levine and Thomas. It was really a very rich, and I think, meaningful contribution to the whole course. And I think we'll be carrying this teaching and what we heard from you with us and throughout this course and discussing it. I feel it's just the beginning of what you brought to us. So thank you so much.