‘B’ is for Behavior

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We usually consider avoidant behavior as part of the constricted behavioral patterns of PTSD. Avoidant patterns can appear in a multitude of ways, and I want to share one client story that points out how show up movement patterns.

Julie (not her real name) first came to me for physical therapy for treatment of her chronic ankle pain. Falling down a flight of stairs and fracturing the end of her fibula nearest her ankle caused this. She had clear structural stiffness with decreased passive and active range of motion. Her pain was worse with movement than when weight bearing. It required manipulative physical therapy (deep soft tissue mobilization, stretching and joint mobilization) as well as strengthening to balance her functional mobility. Manual therapy also focused on easing specific fascial (periosteum) constriction/activation. Her pain, strength, range of motion and walking all improved significantly with the appropriate physical therapy, but she continued to have a nagging ache when she walked.

So, I watched her walk. I do this with most clients, whether it is for physical therapy or psychotherapy because it gives me a general sense of how and where constriction (activation) is held bodily. I noticed that each time she walked passed a chair on her right she ever-so-slightly-leaned toward her left and compressed the right side of her trunk.

I pointed this out to her and asked her if she was aware of it. She was not (numbing/dissociation) so I had her slow her walking down and stop the moment she noticed she was leaning. “Are you leaning toward the left or away from the right?” I asked. She processed this question somatically and realized that, “I am leaning away from the right.” (Avoidance due to higher sympathetic charge, in other words, flight). I asked her to bring her awareness into her body and track whatever she noticed next—movements, images, feelings and thoughts. SEP’s will recognize the basic principles of SE: stretch time out/slow down, track sensation and other elements of SIBAM, defensive orienting, sympathetic activation in readiness for action, in this case a defensive response of flight.

To Julie’s astonishment, she fearfully (upward constriction of her pelvic floor, faster and shallower breathing, slightly widened eyes and verbally expressing, “This is weird, almost scary”) recalled how, just before she fell down the stairs holding the laundry basket (left hand/arm), she reached for the banister on her right side. The problem was that the banister had been removed for painting and the lack of banister became the threat from which she fled (leaned away). This was complicated by being off balance. Her next comment reflected how her attachment strategy or developmental trauma overcoupled with the shock trauma: “There was no banister to grab onto just like there is never anyone there to help me.” Since she was in the midst of feeling the thwarted protective and postural reflexes unavailable when she fell, I chose to stay with the shock trauma and return to the developmental trauma later. This started the process of uncoupling the two.

Julie's movement pattern of attempting to reach to the right (frozen impulse) with her arm but falling to the left created a local tonic immobility of her righting reactions (orienting to body) and equilibrium responses at her ankles. Protective extension was useless because "Everything happened so fast." In other words, her defensive responses were thwarted. The impact injury or the fracture was painful, but the traumatizing 'stuckness' or tonic immobility of her autonomic nervous system was from the moment she was unable to protect herself from falling. It manifested in a dysregulated, dysfunctional movement pattern and chronic pain. From the moment of her realization about the banister and attempted but incomplete protective response we 'worked the fall' as a Somatic Experiencing® Practitioner typically does—slowly and gradually facilitating her capacity and ability to manage protecting herself with a greater sympathetic action by uncoupling her fear from the immobility. She was guided to feel the impulse to reach, the micromovements of her ankles and the righting or orienting strategies of her neck, head and eyes, and the rotation of her trunk (the frozen compression I had observed when she walked past the chair initially). As these came back 'online' her fear diminished and the activation associated with it discharged and settled. She needed only two rounds or titrations to feel complete with this. Her pain alleviated as her somatic protective reflexes came back online and her tonic immobility patterns, particularly the more complex ones of her ankles and trunk thawed.

I had her walk across the room a few more times and she walked with flow and balance deviating neither left nor right when she waked past the chair. After this session she was pain free, and, needless to say, felt greatly relieved. She was also able to walk down the staircase in her house without holding the new banister.

Her attachment strategies of life included avoiding intimacy. She was unable to trust that her mother would ever understand her needs, and her father, whom she longed to be with, was often traveling for work. Her psychophysical interpretation: "no one is there for me so don't bother reaching out for help". Of course, this manifested as a belief and in her experience falling down the stairs. While this might make little logical/rational sense, it makes perfect somatic sense. As we 'worked' the fall and I asked her to notice how it was for her to accept my help, she

initially felt simultaneous dueling impulses. "I can do this by myself" and, "but I guess I need him to help me." Her capacity to verbalize these dueling impulses helped to further uncouple the shock from the developmental trauma and the affect (fear) from the tonic immobility. In the transference relationship, she came to understand somatically and affectively that she does not have to experience herself as alone in the world and that help can be had. Her belief started to change.

The 'B' of SIBAM includes movement behaviors. Observing movement patterns opens powerful lenses through which to see affects and behaviors associated with PTSD. This is essential with all categories of trauma.