Seth (00:00:00):

Right.

Irene (00:00:00):

I'm throwing you off.

Seth (00:00:01):

Yeah. All right, let's start that over. Hello. Welcome everybody. This is the special topic Q&A call for SBSM 15 on shock trauma with myself and Irene.

Irene (00:00:14):

Hello.

Seth (00:00:14):

And so yes, we wanted to start off. I'll just talk a little bit about what shock trauma is. So these are discrete individual events. There can be certainly more than one, but when we're talking about a shock trauma, we're generally talking about what most people think of as trauma. So like an assault, getting blown up. Having surgery can count at an early age, especially if we don't understand what's happening. Big things that are overwhelming for the system. Now sometimes that will include injuries. So another definition of trauma is in the medical world when we have injury to the tissues, to the body, that can be considered a trauma in the medical model, and that can come along with unresolved survival responses as well.

(00:01:02):

So especially when freeze has been established really early on as sort of a go-to, we will have a tendency to often store away the physical aspects of shock trauma, which we'll get into in some of these questions that we got. Those literal impacts and what we call force vectors that are in the system can be part of the survival responses and emotions that are stored up. So these are all the kinds of things that we mean.

(00:01:34):

Now, early developmental trauma, chronic stress, these are slightly different, but shock traumas can be part of that. So maybe we grow up in a stew of just chronic stress and misattunement. That's early developmental trauma, but then there may be discrete events within that that are shocks to the system. And that's really how we end up with what we call complex trauma. That's when you have usually early developmental trauma and also shock traumas on top of that. So hope that is all clear and we will get going with the questions, unless Irene, is there anything you want to add to that little intro?

Irene (00:02:13):

Nope.

Seth (00:02:14):

Great. Okay. So this first one's for me. We didn't get an overwhelming amount of questions this time specifically about shock. Some we sort of included because they are relevant enough that we can teach about shock trauma. So it may not be a super long call today. So just wanted to let you know that.

(00:02:34):

So this first one is for me and it said, "I recently experienced a shock. My mother died. Everything I've gained from the work feels like it's been ripped out from under me and I'm starting all over. My health issues have come rearing back. Before she passed, every time she left the house, I would feel terror and collapse at the same time. And our relationship has always been chaotic. I feel like I need her, I want her, and I hate her. What is happening? Anything else you can suggest on top of the nervous system basics I am using to bring myself back from this shock."

(00:03:13):

Yes, this is something that is very normal. When we have a big shock to the system, even if we've already been doing this work for a while, it can certainly make us feel like we're regressing. Old symptoms can come flooding back. All of what you describe is not unusual because when we're progressing in our regulation and building it, there's still the old wiring there and the old patterns there. So it's not surprising if we get a big shock to the system like this, like someone that we are closely connected to passing away, that our old adaptations, our

old symptoms will come flaring back for a time. So just know that that's not unusual and it certainly can pass. And it is important to know, though, how to take care of yourself.

(00:04:07):

One of the things that's pretty clear is that this was a complex relationship. It sounds like there was trauma in the relationship, in the attachment dynamics, even up until death. So it's not like it was necessarily just a peaceful relationship that then had this end. It sounds like it was unexpected and the relationship was complicated. So that does make it more problematic. There's lots of conflicting emotions.

(00:04:35):

Now when we lose someone, it's totally normal to have anger, rage, a sense of betrayal, as well as grief, sorrow, hurt, loss. That's not unusual at all. It's sort of the normal stages of grief. Denial is another one. However, when there's been trauma in the picture, all of that can be even more exacerbated, more complex. So first I want to say, I don't think that you've lost all of your gains. It's just that your system is overwhelmed right now. Everything that you've learned, all the work that you've done still is valid. It's just right now you're being flooded because of this understandable shock, and yes, this destabilization.

(00:05:20):

I remember when my mom died, even though I was regulated pretty much fully at that point, it felt very strange. It felt destabilizing. And it wasn't as extreme as this, but it definitely rocked my boat a bit. So yeah, it's a big deal. It's very important to rest a lot, to not try to do too much, to make a lot of room for self-care using your resources, all your tools like you talk about. With grief and these types of complex feelings, it's also really important to allow what you're feeling without judgment. So hopefully understanding that this is all normal will be helpful. Now, it's also really intense. So that allowing also has to be titrated and bridged with resourcing, supporting yourself, checking out, taking a break, having a cocktail, watching a show, whatever it may be, whatever your resource is. Allowing yourself to use your resources to not be so in it for a while if possible. And when you are in it, doing your best to allow it.

(00:06:36):

So this is a lot about making space in the system. So the diaphragm lessons certainly come to my mind, thinking about how you can bring capacity, space into the chest, into the pelvis, into the diaphragm, all through the torso. The emotions of grief can be very intense and we need to have space to allow them to move through. Allowing yourself to make sounds. Let the body express. Grief is meant to be usually quite a loud experience. There's many cultures where they have these wonderful grief rituals and practices where the whole tribe will join together in wailing and moaning and just emoting. So it's like this communal expression of energy and emotion. We don't have that so much unfortunately. So allowing that for yourself as much as possible. Let the sounds come out. Let the snot throw through the nose. Let yourself be a mess. It's okay. And then use your resources. It's okay to pack it up a little bit. Distract yourself.

(00:07:51):

So that's sort of the best I can advise. Work to bring space into the system. Use your tools of expression. Allow the emotions to come through. It's okay if you feel anger. It's okay if you feel this sense of hatred. That's part of it. Allow it to come through. Allow the sounds of that to come through. What are the words that maybe want to be spoken if you could speak to your mom? And then balance all of that the best you can with a lot of rest and a lot of resourcing and self-care. Irene.

Irene (00:08:27):

I'll just add one more thing, just speaking to one of the things in the question they wrote. "Whenever she left the house, I would feel terror and collapse at the same time." So now that this person that caused that is not there, there's a pattern, a familiar pattern. While it's dysregulating and chaotic with terror and collapse, it's not there anymore. So you've gotten comfortable and familiar, I should say, with that pattern and now she's not there. So there's also maybe a void or maybe this, "I'm not having to go into that pattern." So just be aware. I'm not saying do this or that with that, but just be aware, "Wow, there's this pattern that I used to have and now that my mother's not here anymore, do I go into that?" So sometimes when something shifts out, there's an opening for something new to come in. So that's just something I wanted to add.

(00:09:43):

And then the other thing you mentioned, "What else can I do on top of the nervous system basics?" This we could say maybe falls a little bit out of scope of what we do in SBSM, but if

you have any spiritual practices, soul- based practices, connecting with her on the other side, ancestry, the energies that were good, was there something good in that relationship? We could say, well, she created you and brought you into this world. So again, it can take time to mend and heal those things, but sometimes to look a bit beyond just what's happening in the physical, but also the energetic can be a useful thing. And I would say that cultures that have deep faith in other practices, often I find they do a little bit better when it comes to death and grieving because there is a connection to another source other than just their own system that they're maybe overwhelmed with. So I hope that makes sense, but wanted to add that in as well.

Seth (00:10:55):

Yeah. What you said sparked up one more thing for me about, yes, if that terror collapse cycle is gone, it's possible there may be a sense, at times, of relief. And that can be quite confusing and it makes someone feel guilty, but that again would be totally normal to have a sense of relief that this stressor is gone from your life. So again, grief isn't logical. It goes all over the place and to just have acceptance for yourself.

Irene (00:11:28):

And someone said in the chat here, so we'll just acknowledge, or a sense of relief. We can see someone freeze affecting us and excuse them but deep down there's anger. I'm thinking about two friends right now, whom their mothers, both mothers passed. One more recently and one a while ago. But what they didn't realize, and this actually connects really well with your question, they were constantly on edge waiting for the next thing to happen. Whether it was, "I'm going to have to go to the hospital, I'm going to come home to something not good." There was always this worry, this monkey on their back. So there is no shame in being like, "Oh, this is good. This is good she's passed over, it was time," et cetera. So again, it's a strange one, but we also have to honor those who have passed. They've had their time here, they're moving on and now we focus on us.

(00:12:28):

Okay, next question... Oh, by the way, we're saying like Seth, "This is my question, this is my question." People didn't write in saying I want Seth or Irene to answer. We just divvied them up equally. So we each have six questions.

(00:12:42):

Next question: "There is one specific shock in my system that often blocks progress. I work around it and shift it a little bit, but then it emerges and there's kind of a shutdown. How can I get this huge ball out of my pool first? So in the third training call, Irene mentioned that sometimes you have to release a huge ball first." So if you don't know what I'm talking about, go back to really the first training call. We also got into this. "Working on capacity is helping, but in this case I feel I need the ocean instead of a swimming pool. Thank you for any thoughts, ideas, or maybe practical examples."

(00:13:27):

I'm going to go back to the second sentence of this question, which was... So again, just a reminder, this person's saying they think there's one specific shock trauma that's kind of blocking their progress. "I work around it and it shifts a little and then emerges, and then there's a shutdown that happens." So I guess my direct question would be sometimes we have to work directly with it. So that might happen with your own processing, working with the memory of the shock trauma, working with the sounds. These are just hypotheticals, for example, sensation, the image of what was occurring, who was around you, what behavior did you do or don't do.

(00:14:18):

I'll just use an example. Let's say there was a car accident and you tried to get out of the way, but you couldn't. So that movement of wanting to get out of the way, you didn't get to complete. This comes back to those stored procedural memories. Sometimes we can work with these directly with ourselves with enough skill, and that's possible. Sometimes we need to do some work with someone else. So someone who's trained to help guide us through... In the SE world, at least, in Somatic Experiencing. So this isn't my lingo, we would call it the T model. It's not about a car, it's about time.

(00:14:59):

So if you think about a spectrum of time, you had this shock trauma and it happened at a specific point in time and we would call that T something. There's before the shock and there's after the shock. So we would say T minus one was right before it happened. T minus five was the day before. T plus one is, whoa, I'm sitting there on the curb looking around going, "What

happened?" T plus 10 would be I'm at the hospital getting an X-ray to make sure I didn't break anything.

(00:15:33):

So if we think of this model, T model of spectrum and time, one of the things that we could work with ourselves with this pre, during and post, is all the qualities of feeling, sensation that were occurring leading up to, during and after. Sometimes that's too much for one person to travel through on their own. And this is where working with a practitioner for maybe one or two sessions to just help, kind of lodge that big ball out of your pool, can be helpful. The interesting thing is sometimes the T, the actual ground zero, and Tamar just said the T is zero model, sometimes people think the ground zero, like the T zero is the accident. That's not always the case.

(00:16:27):

Let's just say, and this is a terrible example, but it's the one that came to my mind. Let's say someone is in a car accident, but their T zero is when they realize they killed somebody in that accident. That's more traumatic than the accident. And so you actually are like, okay, that's the hotspot. So we're going to work around that hotspot until there's enough capacity to be in the pre pre T and the post post T. So that would be an example of how you might work directly because sometimes we can't walk around it. It's like we gotta go right through and have the heart rip the bandaid off kind of qualities.

(00:17:18):

I think that's what I wanted to answer. Working on capacity is great, working on the basics is great, and when we've had specifics, sometimes we need to work directly.

(00:17:33):

Another example might be, let's say you had... I'll just give another example. Maybe there was a broken bone or some kind of shock. It might be that the work that you do is not with a trauma therapist, it's with a body worker. Maybe there's adhesions around the bone or something stuck and I'm going to say this, no amount of orienting is going to get into that. I mean, maybe in some world there would be, but sometimes we need another person to come in and manually move tissue that's been so scarred, for example.

(00:18:08):

This is something I personally have had to do more work than I care to admit around all my accidents and injuries and broken bones, but sometimes that's what we need to do. And you know it's working because after that session, you feel a little shaky. It isn't just a nice massage. You might get a flu-like symptom, but it's not that you have the flu. It's literally something shifting in your physiology, rearranging around that opening. So that would mean that, oh, I got the ball out because I actually feel... I feel different, and there might be something that comes out emotionally from that or dreams, et cetera. Seth, add anything you wish to that.

Seth (00:18:53):

Great. Yeah, it is a really important point that sometimes a session or two even with a one-on-one can be really helpful for these specific things. I've got a couple clients who I don't see often, and this was how I was too in my last couple years of doing this work for myself. I do the work for myself, and as capacity grows, you get to be able to do more and more for yourself, but then eventually something arises that's like, "Ooh, this is big. I need some help with this." And that's when you go get some help. So yeah, not unusual.

(00:19:31):

The only other thing I thought of is when you say, "Working on capacity is helping, but in this case I feel I need the ocean instead of a swimming pool." And then you ask for any practical ideas or images. What's it like? What would it be like to use that image of the ocean? When you come up into sensing that shock, that specific thing, to really... Okay, what's the image of that thing? What's the image of this one specific shock? Maybe it's like a person involved or maybe it's just abstract. Maybe it's like a brown block of wood. Who knows the way that our imagination will interpret it. Just accept it, whatever it is. What's the image of that thing? And then can you see that in the ocean? Can you see the image of that in the vastness of the ocean? That's one way to use imagery to work with a sense of more space.

Irene (00:20:26):

Can I add one more thing to that?

Seth (00:20:29):

Yeah, go ahead.

Irene (00:20:30):

Well, I think too, and perhaps you've already said this in your training or your Q&A call stuff, but sometimes there's this confusion, because at least some of the work we do, Somatic Experiencing or somatics, which I don't love that word, but we use it. People assume we're going to work with the body all the time. And so what you just said, sometimes we're working with the thoughts, but from a sensory based way or we're working with a behavior and we're noticing what's happening internally. So sometimes there's this, we're trying to choke our sensations like, "What's the sensation? What's the sensation? I don't have a sensation." Well, it's possible you don't have a sensation, and that's fine because the system is still protecting that sensation because the shock of that trauma is still so fresh and present. So again, using visualization is totally valid. You're not moving outside the scope of doing somatic work.

Seth (00:21:33):

Absolutely. Yep. All right.

(00:21:37):

"Every time I have someone in my life that I love romantically, I also get a sensation of pain in my solar plexus. This happens regardless of who the person is and I've experienced in my previous relationships. Could this be a trauma tied to my first experience of love or the feeling of pain somehow became coupled with that feeling of love? My first experience was a painful one. How can I work on resolving this so that I just feel the love without the pain?"

(00:22:07):

So a couple things here. One, love and pain, at least to some degree, I think are always going to be together at least a bit. And that's because love makes us vulnerable. When we are in a state of love, we are in a state of vulnerability, and so that can lead to fear of loss. When we love someone, then we have the fear of losing that love. So at least to that extent, a little bit of pain, kind of is inherent in love because it's the only way that we come into that vulnerability of losing that potentially. So to some degree it's normal, but this sounds a bit more specific. And the reason why I included it in this call is it sounds like with your first experience of love, there may have been a shock, like a sudden rupture or a betrayal, something that ended it suddenly. I don't know that for sure, but it could be, and that's why I want to talk about it

because this pain that comes in your solar plexus whenever you feel love, sounds quite specific. It sounds like something that might happen if a shock might get stuck.

(00:23:31):

So for example, when we experience a shock, one of the things that will often happen is this... This inhale that's right directly into that area of the solar plexus. It may be that some of that direct experience of, like, shock inhale is maybe stuck a little bit. I'd be curious to explore what it's like to work with breathing mindfully with the diaphragms in exploring, like, is your breathing diaphragm able to move in the ways that it's supposed to? Is there an area where it feels a little rigid? Working with the layers lesson with this in mind might also be useful. Coming into contact with that area that feels pain and exploring what's happening in the fascia, what's happening in the muscles, what's going on as I breathe? Can I also feel with my hands?

(00:24:28):

And that love-pain intertwining can certainly be much more intense when there's been paths lost, because another thing that can happen is we can build up armor, we can build up armoring around our heart space that is literally in the tissues. So as you are experiencing love and softening into that connection and vulnerability, then the armoring becomes much more apparent. And that could also be what's happening here is you're feeling how you're protected yourself and are braced on the inside. And if that's the case again, it may be useful to work with that idea of the layers and also the diaphragms working with touching in from the outside and expanding from the inside. And this again, may be a case where there's some kind of physical manipulation, some kind of assistance that needs to happen with bodywork, even either in the chest or in the back of the chest. It may be that we want to get some work done. The mediastinum is a really powerful place to work in this regard and maybe connected to what's happening. I can't recall, are we at the mediastinum lesson yet? Yeah, that's out already. So, working with that mediastinum lesson might be useful as well, getting mobility and softness into those structures.

(00:25:59):

Let's see. Anything else? Working with the inhale, the exhale, working with, if you breathe into that constriction in the solar plexus, is there a sound that naturally wants to come out? What's living in there? How might it be expressed? These are all things that would be helpful to explore. Irene, anything you want to add to that?

Irene (00:26:20):

Yeah, one thing and then I'll get to the next one. Again, I'm not saying this is what it is, but it's what came into my mind as you were talking, Seth, with this question is if we go way back to when you were an infant, and of course I don't know the history with your primary caregiver, most likely mother, but if she was offering you love, but she herself was in pain, if she had a lot of anxiety, even with that love, there could have been what we would call an over-coupling where you're feeling, "Yeah, mama's here, but I'm feeling something off." What is that? And that could be that she's in her own dysregulation, which is pretty normal these days. Maybe she's in a tumultuous relationship, maybe she had you and that same week her mother died, or she had a death in the family, so she's feeling tons of pain in her heart and yet she wants to be present with you, but there's this paradox, "I want to be joyful, but also, I'm grieving."

(00:27:32):

So again, I'm not saying that that's what it is, but these are some of the things that when we get more nuanced at noticing subtleties, this over-coupling of things can be something there. All right, next question. “I have a question about symptoms changing when doing this work. So when symptoms change, I'm wondering if I have resolved anything or if the trap charge is just moving to a different place.” So I'll answer that first. That's very possible, but that doesn't mean that something isn't happening. That's good. The system will move these things and trust me, it can be really frustrating when you're working with this stuff because you're like, "What? I just got this better and now this is all weird and tight," or, "I just had this shift and now this is da-da-da-da," so it's part of the process.

(00:28:28):

"I used to have pain in my back and shoulders and after working with that, I got tension headaches instead now. When that is better, I have nerve pain in my hands and arms making it hard to use them." So, this actually makes a lot of sense. I'm just going to break this down. I'm experiencing this right now, so if you've had a lot of injury or bracing and you're working with the body, so when you loosen up the pain or the tension in the back and the shoulders, this area, and there isn't the grip, it's going to move. And often, it moves up to the neck and the head and the jaw. And then, let's say you move that and then it's like let's pick somewhere else, and then the arms are quite close, and this area of the armpit, there's so much in this area here, anatomically very complex area, this thoracic outlet. So, I just want to normalize

that this is really common and you're not crazy that this is moving around. This is very common, and it can often be what's called the will structure as asserting itself somewhere else, "This is better, now we're going to go here. This is better, now we're going to go here," and it's kind of like a wild goose chase. But what we want to do is these things move. We want to try to not get frustrated with this moving and accept this is the next layer, this is the next layer, and then support in the way you might need, whether it's resources, whether it's some easy body work, whether it's warm baths, whether it's just breathing and being in nature, the things that you know will help you settle the overall nervous system.

(00:30:26):

And you say, "The doctor says it's all fine," which makes sense. It shows this is very much nervous system related. It's invisible in some ways, "Any ideas on how to approach this, especially the nerve pain that is debilitating and makes me anxious?" So, the keyword for me there is anxious. And I also understand, I remember there was a period of time for about a month where I couldn't push myself up with my hands, when you're in and you prop yourself up a little bit. I don't know what that was, but it was excruciating. It is as if I had broken both of my wrists, they were so weak, and my sense is, it was from old fractures of my wrists back in the day. So, how can you sense this pain? And I understand it's debilitating, but almost befriend the pain, talk to the pain, see what it wants to say.

(00:31:29):

If you were to tune into that nerve pain, is there an image? Is there a texture? Is there a sound? Is there an action? Is there a bunch of words that want to come out when you feel that pain? Because what'll happen, and again I'm making a generalization, but when we can be with that pain in a less fight-flight freezy way, it allows it to open up a bit more and not get trapped because to go back to that idea of we want to have flow. This goes back to training call number one where I had you draw the little circles and we want flow between things. This ability to, even though it's painful and it's debilitating, how can we be like, "Ah-ha, this feels painful, this is debilitating and I'm going to sense it and I'm going to feel it and I'm going to do what I can to be with it."

(00:32:22):

And I will say, having been there, it ain't easy, so you need to be gentle with yourself, you have to remind yourself this is part of the process, and because you've had it medically looked at, it

would be different if it were an actual pinched nerve somewhere that was limiting and an actual vascular problem. But if there's warmth and you can move, then chances are the neurology and the vasculature is fine. And then, the other thing is how are your other core organ systems doing? So, is your digestion good? Is your immune system getting stronger? How is your energy? So sometimes the way we know that we're still on the right path is that our autonomic functions are continuing to grow capacity.

(00:33:19):

Our core systems are strengthening, they're becoming more robust. If we maybe we're not getting sick as much, or if we do get sick, we recover a lot faster: these are all signs that we're improving. If you can, again, I am a big fan of good, gentle body work. Sometimes it can be useful with this kind of bracing patterns to work with the practitioner if you can to help move the muscles, help move the joints. But I would also say Elia's lessons, some of the movements with the hands, and you don't have to do them big, but just little bits just to get that flow going through the limbs can be useful to keep the activity in the arms and in that. So, add anything that you wish, Seth.

Seth (00:34:14):

Oh, just a couple things.

Irene (00:34:16):

Yeah?

Seth (00:34:17):

One, just to note that this paradigm of something shifting and then something else pops up. And the connection that you first described as classic like yeah, the shoulder relaxes and then I get a headache. This is all the kinds of stuff that we see a lot when freeze may have been in the picture from an early age and the system learned to just hold stuff, and that is part of what Irene was talking about: will structure, "I'm going to bear down and make it through," and that it can take a long time to shift those things.

(00:34:53):

And when we shift it to one area, the system may be like, "Well, to hell with you, I'm going to come over here," so it can take a lot of patience and this is also something that can happen a lot when there has been physical injuries and shocks within the context of that freeze. It can also happen with just chronic stress in the context of freeze, like growing up, just feeling constantly stressed and sort of bearing down to get through. So there's different ways it can happen, but it is, yeah, Irene has lived this –

Irene (00:35:26):

Living it right now.

Seth (00:35:27):

Living it right now. Yep.

Irene (00:35:28):

And I had a headache for three days last week.

Seth (00:35:30):

Mm-hmm, yep.

Irene (00:35:31):

And it wasn't because I was doing anything stupid or crazy or hungover. I am working through the next final layers, but lo and behold, my legs, because even with all the injuries I've had there, they're the best they've ever been. So, that's what I say: can you notice what is getting better and then be patient with these other pieces? The one thing I forgot to mention, the lesson finding the painful and the pleasant that's about teaching this pendulation, so if it's just too much to befriend that nerve pain, then don't. Befriend something else. Befriend the trees, befriend the hot cup of tea, the music. This is where you use your resources to take the edge off of what is being felt in that moment.

Seth (00:36:26):

Yeah.

Irene (00:36:26):

Okay.

Seth (00:36:30):

Okay, " Hi, Seth, you mentioned that surgeries in babies or small children are often traumatic for them. My baby, 10 months old, has a lip tie and I could wait to get it corrected. The fear of the trauma for her is my big concern. But what if a baby or small child needs surgery that can't be delayed? How do you prevent or heal any trauma?" Yes, this is a very common shock to young systems, a need for surgery. So, I'll address that end part first: what if there is a surgery that can't be delayed? How do you prevent or heal trauma? So, a lot depends on the age of the child. If they're old enough to understand cognitively what's happening, then that can help a lot for sure. If they are before that age, when there is no ability to understand cognitively what's happening, there's no real voiding. I think the fact that it is going to be highly stressful for them, and possibly traumatic.

(00:37:37):

However, you can do a lot to ameliorate that and help them recover. In any case, the rules and the guidelines for going into any surgical experience are basically the same. We want to be as safe and as connected as possible going into it. So as the parent of the baby, I would fight damn hard for my right to be with that baby as long as possible. And if possible, even during the surgery. Now, that may not happen, but at least you can be as much as possible to the point of that, be with them. And as soon as possible afterwards, be with them: that's the most important thing is you just want to have that connection, that secure connection and safe connection for as long as possible up to the point and as soon as possible after the point.

(00:38:37):

And then in terms of afterwards, just lots of nurturing, connection, I would not leave baby's side, I would just be with them all the time, lots of skin on skin contact, lots of nurturing touch, understand there may be a lot of distress that needs to move through the system, there may be a lot of crying, there may be depending on the age, again, may be anger that maybe comes out frustration, anger, aggression may be ramped up, which may express in different ways depending on the age. Understand that's normal and you want to support that as much as possible, not try to prevent it. You want to help it move through in safe ways as much as possible. So maybe your little one is pulling on your hair a lot afterwards or grabbing or something and it's like, "Okay," you just try to let that happen the best you can.

(00:39:36):

And then I advocate for them, like, say, "Wow, you're really strong. Look, I can feel your strength. I can feel your energy," and try your best to celebrate the fact that they're processing this, even if it's uncomfortable for you in the short term. You could also give kids of different ages, different things to squeeze, to hit safely if they just want to hit something, set them up, give them some pillows, you could do it with them. Just supporting them in their expression as they need, and that connection piece is so important, just being with them as much as possible.

(00:40:17):

So in regards to lip tie surgery itself, I'm certainly not an expert in that. I did read up a little bit on it. It sounds like there are some ways to do it that are very non-invasive and virtually painless. At least that's what they say, who knows what the reality is, but there's the laser surgery version that it sounds like is super quick and doesn't cause much discomfort. So it may be that it's in the realm of surgeries, this isn't such an awful one. Also though, I did see in exploring a bit, depending on the severity of the lip tie, there are some other non-surgical things that a person can do that are more in the stretching, massage, chiropractic realm of things. So, you might want to consider exploring that too. That's all outside of our scope, but I just thought I'd mention it because I was exploring a bit and saw that, "Oh, well, it looks like there's different options for this kind of thing." And if you can wait until your kid is older and can understand a bit about what's happening, that could be useful as well. If it really is needed, then you don't want to put it off too long: it depends on the case of each individual.

Irene (00:41:35):

The other thing I would mention is the word here that stood out to me is, the fear of the trauma for her is my biggest concern. So for a mom, that's something you're going to need to work with because sometimes the fear that the parent has around their kid is worse than the issue. So, if a kid is going through a hard time or an accident or they have to have a surgical intervention, if the parent is freaking out, that is not going to help. And so, tons of kids have surgeries, and they're okay, so we know so much now, medical surgeries are pretty darn good, the chances of you being in an operating room, the law I don't think would allow that. But here's what you can do: connect with her when she's in there. So this is where we bring in that knowledge, that distant prayer works and energetically connecting with someone who isn't in

the same room with you is a real thing, so you know your child better than anyone as soon as they go hold the intention of healing of safety, work with yourself. Because again, if you're in that energy of worry and fear and stress, that is going to influence her recovery and her safety. I know Kathy Kain always said to us when we talked about surgeries and anesthesia, don't challenge too much, the anesthesiologist or the doctor, because what will happen is if you challenge them too much, they will start to not like the case. And when they don't like that, what is going to happen? That's going to influence how they go into that surgery with your child. So you don't want to just let them walk all over you, but you also want to be respectful that these are the experts and they are dealing with drugs that you know nothing about, and they've done it all the time, and just, you also want to bring respect into that medical community because that I know for a fact that will influence how the surgeons interact with your baby when you are not there. So, be very careful about that fear.

(00:44:10):

And I would say I didn't have time to look this up, but I do remember reading somewhere, I'll see if I can find it, that some fascial inner oral work can occur to shift that. But the thing is with an infant, that could be actually more traumatic than getting the surgical intervention. If you've ever had inner oral work, it can be very painful. So, if there is something that fascially just needs to be released, it could be that that is the easiest way to go. But again, not my expertise. I just wanted to add that in there.

(00:44:47):

Okay, next question, "I have periods where I wake up," I need my glasses, "Where I wake up around two hours before my alarm, totally relaxed, thinking hopefully I don't get anxiety again that will keep me awake." I'm going to say that again, "I have periods where I wake up around two hours before my alarm, totally relaxed, thinking hopefully I don't get anxiety again that will keep me awake. This is followed by mild anxiety that used to be much stronger years ago, which keeps me from sleeping. I know from the past that suppressing the thought helps. But now, I wonder if the thought itself is maybe a sign of survival energy surfacing. Is only the thought making me afraid or do I get the thought because of the old trauma? How to work with this?"

(00:45:44):

So, it's like a chicken and egg situation here. But the first thing I'm going to suggest is when you wake up, feel relaxed, stay there. So in other words, you say, "Hopefully I don't get anxiety again," so our mind will play tricks with us. We'll be like, "I'm awake," and if we are instantly, "Oh man, and then we're worried and we gotta get up at 8:00 and now I'm going to be tired for my thing," that thought process will definitely keep you awake and that thought process will hit you into sympathetic fight-flight. So how can you, when you wake up, and I've experienced this, I think many of us have experienced waking up in the middle of the night, what do you do? Can you go back to your basics: feel the bed, feel the covers, maybe your eyes are open, let your eyes be open and see, but kind of go back into just not trying to force the sleep, but be in the moment.

(00:46:54):

Now, if something is waking you up and it is an old survival stress that is making your heart race, then you might need to get up and run on the spot, or maybe you need to do a movement or a sound or something like that. But if none of that is there and something's just waking you up, how can you stay in that relaxation and see what happens? The other thing you mentioned here is, "I know from the past that suppressing the thought helps." Sure, and how can you work more gently with the thought? So, let's just say the thought comes in because it's gone up, because our wiring is strong. So, when you catch yourself saying to yourself, "Hopefully I don't get anxiety," and this is just one example, how can you have a little comedy routine with that, like, "Oh, there it is again. There's that thought that I know is there," and just think that thought, "Oh, here you are," you're wondering what's going on? And then can you just go again? Go back to the body, go back to the sensations, go back to the breath. But yeah, that subconscious or conscious thought can really be masterful at keeping us awake or other things. And so, how can you work with that thought?

(00:48:24):

I had something else go through my mind and now it's left. Oh, this again, a little bit out of scope, and I know through doing enough nutrition work and metabolic studies that sometimes we wake up because we're hungry. You may not feel hungry, but if your blood sugar drops, that can be a sign that something is, well, the system is like, "We need to wake up because we're going into low blood sugar," so there's this debate about you shouldn't eat anything two hours before bed or five hours before bed. But for some folks, and I find this is more true for us women when we're approaching perimenopause, menopause, we need a little protein and fat

before we go to bed, and that'll help our cortisol levels stay where they need to be, and it'll sustain us through the night so that we're not waking up.

(00:49:24):

Now, you might not feel tired when you wake up two hours before, but that can sometimes be the sign of just needing a little bit more nutrition before you go to bed. And I don't mean sugary snacks before bed, like something like a nut butter or a piece of fish or something that's just more wholesome and fatty and protein-based. Anything you want to add to that, Seth?

Seth (00:49:52):

Yeah, the reason I thought this would be a good one for the call is because I don't know what the source of this is, but this is a normal thing that we would see if there had been, say, shock to the system, or repeated shocks to the system, while sleeping when we were kids. Getting woken up unexpectedly, conflict in the household, that sudden awakening into stress. It sounds to me kind of like that might be the root of what happened because of how you say it, where you say, "It used to be much more intense." It sounds like you used to wake up with intense anxiety. And that is the classic representation of that sort of shock trauma coming through, and something I used to have as well.

(00:50:40):

And so it's really important to notice the diminishing, that has been happening, and to understand. Because you ask here, "I wonder if the thought itself was maybe a sign of survival energy surfacing." Well, it sounds like it's the echo of that. It sounds like there used to be a big charge in there that would surface strongly in the night and it's attenuated a lot, and now it's much more subtle. And the thought is, it sounds like now the last vestige, sort of like a habit. A habit in the system. And the thought, that little leftover habit, is then just sort of spiking up a little bit of that old survival energy pattern just because of familiarity.

(00:51:28):

So yeah, like Irene said, I think the thing to do is to really notice, one, work creatively with a thought, like she said. Say hello. Say hi to it. Say, "I have the thought that I am worrying about anxiety." Like naming it for what it is as a thought. But then really, how can you really have the intention of orienting to that relaxation that you name? Because you say you wake up totally

relaxed. So I'd be curious as to how you might support yourself to really zone into that felt sense of relaxation while simply naming the fact that you have this thought. Sort of reorienting to what's actually happening physically. That's the only thing.

(00:52:14):

Okay. “Hi Seth. I'm in a new four-month healthy relationship. My partner is very present and intensely focused on me when we are together. The only problem is that when he withdraws his focus from me because of some distraction for a longer time, which is rare, my body starts shaking and stuttering and my head spins. I almost can't talk. None of the self-soothing works. In the bathroom I just want to scream, but I can't. What else can I do? What comes to mind is like the Still Face Experiment, with the baby intensely reacting.”

(00:52:50):

So yes, this, everything you describe is classic evidence of shock leaving the building. So it sounds like there is a big sympathetic charge in your system that, when that intention is taken away, that it just starts moving. And so yes, shaking, stuttering, head spinning, you feel like you can't talk, you want to scream. That's all sympathetic, big ball stuff wanting to come on through.

(00:53:26):

So this is actually an opportunity to work with that, granted you have the capacity to do so. It sounds like it wants to move through. Given the fact that you say self-soothing doesn't work, it sounds like it may be time to work with that energy, and really welcome it to come through. So when you say, "I'm in the bathroom. I just want to scream but I can't." Why not? What is stopping that from happening? Is it your own repression? Is it fear of waking somebody else up? I would want to know, what's stopping that from emerging? Because it sounds like that vocalization is going to be a part of what wants to happen here. And one way to start negotiating that is to work with it quietly. So it may not... this is something that is kind of unusual, but why not explore the effect of the scream with a much softer voice?

(00:54:38):

And one thing to note: full on screaming is not always the best. It actually can be overstimulating for the system, and we can hurt our vocal cords. That can be too much. So it

sounds like there is an expression in that territory that wants to happen, and know that you actually don't necessarily want to just, yeah, fully, "Ah!" You want to work your way into that as your capacity allows. So that might start with maybe just working with the effect of the mouth opening. "Ah!" Quietly.

(00:55:18):

Maybe this breath becomes intense. Even like that, where you're not using the vocal cords but you're breathing intensely through the effect. There's different ways you can titrate that. It also may be that your body doesn't know how to do that scream that wants to happen and you have to teach it. And that, it's funny but we actually had an experience of that once when we were traveling, where we were talking about this kind of thing and Irene realized he didn't actually know how to scream.

(00:55:53):

And so we played with it. And it started out, it was sort of like, "Oh, okay. And now how can you get into your..." I don't remember exactly what we did, but it was working with coming down into the diaphragm a bit more. And so it may be that some of these structures need to open up in order to allow that greater volume to emerge. But it sounds like, from what you're saying, yeah, this is a big ball of sympathetic energy that wants to come through. It's ready to move and it just needs to be supported a bit.

(00:56:25):

Now, it may be that you also need other things like connection. Maybe if your partner's with you and, like you say, their attention is away for a while and you start feeling all this. When they come back, you let them know what's happening and that they can be with you. And maybe that connection will help increase the safety.

(00:56:48):

This may require a conversation about this when it's not happening where you talk to them and say, "Hey, I've noticed this thing is going on when we're together, but then your attention goes elsewhere, I start having this thing happening. So I want to explore what it may be like to have your support with that." So that there's communication around it, which also increases safety. So I hope that all is helpful. It sounds like there's something ready to move and it just

needs some help, either with expression, connection, increasing your capacity, that kind of stuff. Irene, anything you want to add to that?

Irene (00:57:26):

The only other thing would be the fact that the Still Face Experiment came to mind. If people don't know what that is, you could probably find it on YouTube, but it's pretty distressing to watch.

Seth (00:57:37):

Yeah.

Irene (00:57:37):

But it's an experiment where they take infants and the mothers, and the instruction is for the mother to just be blank. And then they film and record the baby going into more and more distress, confusion. They don't know what to do. And it's because she's not attuning to them. There's nothing on her face. They can see her eyes, obviously, and her nose and her mouth, but there's no expression. So this almost feeds back a bit to what I mentioned about the little baby and going into surgery, and I can only make a generalization here, but something that caught me in this question was when you said, "They're intensely focused on me."

(00:58:27):

If Seth was intensely focused on me, I'd slap him. If he's just staring at me and giving me all this attention, I'd be like, "Get away." Like, "What are you doing?" Like, "I need my space." And I say that with humor, and it's funny, but we need to still have our autonomy. And having been in some other relationships where it's all a mash and we're just so in love and then we go apart and you feel like you're dying because you've become that other person and they're everything to you but you haven't kept your autonomy. So I think what would be interesting is, again, this is just experimenting, but if they're not there, if he's not there but he's there, can you sense they're still there?

(00:59:19):

They haven't left. But if we go back to, and again, I don't know your early childhood, but if there were attachment ruptures where you were left alone, where you were left to cry it out at

night by yourself, there could be some interesting... this is going into more early developmental trauma stuff, but there could be some old wounds where being detached from is terrifying and you cannot function.

(00:59:49):

And so part of, again, having a good, healthy relationship is being able to say, "You know what? This happens when this happens and I'm working with it." But to still feel okay, and hopefully they are, if they're still really there but they're not intensely focused on you, they're still there. They haven't left. And we know this from kids when they get dropped off at kindergarten and such. It's like they're screaming and crying, and hopefully the kindergarten is good, and then before you know it they don't want to go home at the end of the day because they're having so much fun. But that initial separation is quite scary for a little five-year-old that's never been left somewhere by themselves. Anyway, I just wanted to put some of those pieces in in case there's also some attachment wounds that could be lurking in that relationship. Not in that relationship, but it's bringing up something from the past.

(01:00:51):

Okay. Next question, going into early developmental trauma: “I've got early developmental trauma and repressed emotions as a kid. Shock trauma at 19 years old, which was a sexual assault, repressed it, repressed this assault, developed various health issues, including LBP…” now, I'm assuming this is low back pain, LBP. “Now in my 40s and recovering from fight, flight, and collapse. When I experience an intense trigger, I still go into freeze and develop low back pain.

(01:01:25):

For example, after a family funeral I woke up with extreme low back pain. SBSM work is helping,” so that's wonderful. Keep doing it. “Coming out of freeze and feeling anger, disgust. I also notice low level back pain in the morning that releases after some of those emotions peak and the system re-regulates.” So the good news is you're noticing shifts, and this moves. It doesn't just stay stuck in one category of intense back pain that never goes away. So you ask, “suggestions?” My one wonder is, you said, "There was a big life event, a family funeral, and then I woke up with extreme low back pain." So that has happened, and that's okay. Not that I say there should be another family event like a funeral, but I'm going to say, what would've

happened after that funeral? Or did you take time to do what I would call somatic first aid? So did you give yourself space after that funeral?

(01:02:34):

Did you allow yourself to do some lessons that evening to take some of the tension, maybe the extra freeze, the emotion? Did you take some of the balls out of your pool, or did that funeral add a few more balls into your swimming pool? So then the capacity shrunk and then that triggered a bit more, where in your case you say extreme back pain. So again, this is after the fact, and that's okay. But this is just a reminder to everybody that, if you know you've had a more stressful day than normal or there's been an event that's occurred, that is your cue to make sure you do at least something that night or that day to dislodge, diffuse, deactivate some of the stressors because, again, back to that crude example of the swimming pool and beach ball, you've added another stress, you've shrunk your capacity. And now the old patterns of compensation, tightness in the back, tightness maybe in the pelvis.

(01:03:42):

As you mentioned, there was a sexual assault at age 19 so there's going to be tension in those perineal muscles, in the piriformis muscles, in the back muscles. So again, it's like your homework, even when you don't have a stressor, is to have a practice where you're doing some self-care, some somatic first aid so that, when you go into sleep, there's just a little less that your system's having to process. Because what'll happen is, when we sleep and we've had a stressful day, if we haven't diffused a little bit of that, our system will have a wrestling match in our sleep. Not literally, but the autonomic nervous system will be tightening muscles, letting go of muscles, tightening muscles, clenching our jaw, and then before we know it we wake up and we're really, really sore and in pain.

(01:04:34):

The other thing, you say, "When I experience an intense trigger I still go into freeze and develop low back pain." So there's a term that again isn't just unique to Peter Levine's work. We would call it prodromal, which means before the thing happens. So the classic example, anybody here who knows what it feels like to get a migraine headache, you know when it's coming on because things start to feel a bit weird. The eyes get a little hard to focus, maybe a little glassy. What would it be like? What would it be like? Now, I know the trigger happens and then it's there and then we're off to the races, but part of this work, as exhausting as it might

be, is to keep awareness on our body and sensations so that we are aware of what is actually having an effect on us that's making a trigger worse.

(01:05:40):

So for instance, I just mentioned prodromal is the sensation you might get before the migraine happens, or in this case the low back pain happens, the freeze happens. Is there something happening before that freeze? Probably fight, flight, that you can catch? It's like the lion's out of the cage. It's fighting, it's fleeing. It's like, before that lion freezes and shuts down, can you catch it and talk with it? "Hey, kitty, kitty, what are you doing? Why are you freaking out? Why is there this fight flight that's going to lead me into freeze?"

(01:06:24):

So a part of this work is doing the pre-pre-pre-prodromal. And often you'll talk to someone and they're like, "Oh, I got this terrible pain at the end of the day." And then you trace back, and this is where that T zero model comes in, it's like, "Oh yeah, I never ate breakfast." Or, "It was extra stressful in the morning because I forgot to do blah, blah, blah." Or, "There was just this series of events that led me to just have lower capacity. And then something happens, I got triggered because there was already a lot more going on in the system. The capacity was lessening."

(01:07:00):

So all these are little bits towards service of, how can you continue to get more skilled at listening to your body and when these pre-triggering physiological things happen so that you can catch it before it goes into the intense pain response? In this case it's the back pain. And remember, something like intense back pain, that is a lack of flow. So that means probably that the vertebrae are starting to seize, the fascia are starting to get frozen, the blood flow is not pumping through there as well. There might be tightness in the belly, constriction. And so all of that part of the body is just like, "We're going to go on strike and we're going to give you low back pain because you haven't been paying attention to the fight, flight before that." Hope that makes sense.

Seth (01:07:58):

One thing I want to highlight with this, too, is where they say, "Coming out of freeze and feeling anger and disgust."

Irene (01:08:05):

Yeah.

Seth (01:08:06):

"Notice how the lower back pain in the morning releases after those emotions peak." So it sounds like you actually are already getting underneath what's going on here, and that anger and disgust is very likely connected to the shock trauma of that sexual assault. So it sounds like you're doing good work here, already working with those self-protective expressions and responses. And it could be interesting to explore doing that even proactively, maybe when you're not feeling the low back pain. Just knowing that, hey, there's some stuff wanting to come through, and really cultivating that.

(01:08:53):

And then there's another thing that might be useful, which was something Peter Levine demonstrated in a master class on sexual assault, which is working with the exercise ball. So getting one of those big exercise balls you can sit on, having it a little under-flated so you can sit on it with a degree of stability, so it's not super wobbly, and then just having that feeling of that support coming up to the entire pelvic floor. And just working with your movements to feel how you can soften the pelvic floor into accepting the support from that ball. Sometimes that can be a helpful part of this kind of work as well because, yeah, that lower back pain is probably everything constricting and trying to be protected, which makes sense. But when you're able to emote and express that anger and disgust, some of that stuff let's go.

(01:09:47):

All right. “I have early developmental trauma and have found that doing some of the exercises have allowed some trauma to surface. If I do the exercise again and nothing happens, does that mean I don't need to do that exercise ever again? Have I healed in that area? An example would be the joints exercise.”

(01:10:07):

So this is not directly related to shock trauma, but I wanted to talk about it because shock trauma often peels away in layers. So especially... and the joints can be a big part of this, actually, in terms of what they hold. So yeah, it may be that we clear a certain level of stuff and we are done with that area for now. But then don't be surprised if maybe many weeks, months, years later there's something else happening in that joint, because it's just the next layer coming through. And this can happen a lot when we have shock traumas associated with physical injury.

(01:10:53):

There can be many layers in which these things peel away. So the most important thing that I want to highlight from this question is how crucial it is. The idea is to internalize all of this stuff so that you remember that you have it as an option. So yeah, it may be that you're done going to that audio exercise, the joints lesson, but don't forget the basic premise of that work, and see if you can have it internalized such that it's there when you need it.

(01:11:28):

That's the purpose of all of this stuff, is not to continue to go back to the audio recording, but that those audio recordings are teaching you that these are tools for you to use all the time in real time without the audio recording prompt. So that's a general guiding thing that's very important for all of this work. This is about teaching you a toolkit. So that being said, you want to have those tools just in your kit available for when maybe the next thing arises. And that can happen a lot with shock traumas associated with physical injuries. Something pops up in the wrist, we work with that, it releases, and then it's fine. Then maybe now it's the shoulders, and then it's the neck, and then we get the headache. And then, oh my gosh, now it's my knees. And then, whoops, there's the wrist again, but it's slightly different.

(01:12:18):

Totally normal for that kind of thing to happen. So that's why it's good to never really think, "I'm done," while at the same time we do want to acknowledge our progress and recognize that, yes, stuff is really seen and it's happening and we just don't know. We want to be open to the possibility that, yeah, maybe there'll be more, and we have our toolkit ready to address that stuff. All right.

Irene (01:12:48):

Okay. Next question. This one revolves around surgery and anesthesia, so just a reminder to stay connected to the ground, everyone, as we talk about this one. So the history is “physical sensations are surfacing from a surgery I had done two years ago to remove a cancerous tumor, during which I was under anesthesia. It feels like something is physically being pulled from me, and separately I feel a flash of the catheter being inserted. I felt relatively calm going into surgery. It helped that I did a lot of grounding, orienting at the hospital during the pre-op appointments. This was great. Very, very good. How to best work with this?”

(01:13:40):

So when it comes to working with surgical events and anesthesia, I wish I could say there's a clear cut path. In some ways, when I think about how we would work with shock traumas and even early developmental traumas, those are much clearer to me than what you do with surgical and anesthesia. However, stick continually with what you're learning in SBSM. Growing capacity, tracking sensation, noticing movements that might be spontaneous. The things that pop out to me with this, as someone who has experienced these things... not the removal of a tumor, I'll say, but I have had drains in my legs and had them ripped out while I was awake, and it's not fun. These memories, these sensations tell us something. Now, I can't assume what this is but I'm going to give you my guess, and Seth might have some opinions and thoughts with this. But when you mentioned, "It feels like something is physically being pulled from me," there's two things that I thought of. When we're under surgery, we're being moved around a lot. And when we're being moved around, you might have a nurse or a doctor that isn't the lightest touch.

(01:15:18):

And I also can tell you, when you are being moved around and you're under, everything is limp. So the way in which you handle a human or an animal that is under anesthesia, it can be a bit clunky, because you're not sure how much force you need, and so you can be a bit rough.

(01:15:40):

And again, I'm not saying that this is what it is, but let's say your arm got dropped on something or something got misplaced, not misplaced, because you still have your body, but you got a little roughed up, not in a bad way, but they had to move you, there might be a procedural memory in you. When you say, "It's like something's being pulled from me," is there a feeling like you want to pull it back? In other words, "Give me back my arm."

(01:16:13):

Maybe a nurse had to take your arm to draw blood to check something. I'm not sure, right? Or do something. Or maybe you mentioned a catheter. I'm not sure if you mean a catheter in the bladder or if something else was. I can't say that word. You know what I mean. There was something plugged in somewhere else.

(01:16:32):

So again, if you're just tracking and feeling this, and you get this sense that something's being pulled from me, ask your body the question, "What do I want to do with that?" And I can't answer that question. Maybe it's a, "Yeah, get off of me," right?

(01:16:51):

And I've experienced processing with my surgeries where I go into a fit of rage. It's like, "Everyone get off of me, everyone get off of me," and I start tantruming. So that's legit when we're working with this.

(01:17:11):

The feel of the flash of the catheter being inserted, again, here is a foreign object going into our body, that is, even if it's done well, that's a foreign object going into the body. So is there a reaction that you want to do with that? Is it, "I want to rip it out"?

(01:17:34):

I know I've seen this with animals. When they wake up after being under, and they still have fluids in them and that kind of thing, they rip those things out. They're not, "Ooh, I better just let my arms sit there." They're chewing, they're gnawing, they're getting this stuff out.

(01:17:51):

And we see this also with people who wake up from surgeries, and maybe there was an accident and they weren't conscious of what happened, and they go into a rage, that's actually a real legit response to waking up after a surgery if you're not aware that that was happening to you. So those are just two little pieces that I would suggest that one plays with around something like this.

(01:18:20):

The other thing is if you go into this experiencing the somatic, experiencing this release of stored procedural memory, just remember, stay grounded, stay present to the moment, know where you are. And the other thing that can sometimes work through when we're working with anesthesia and surgery is we can feel a little dissociated, a little spacey. That's okay, but you want to stay, we would call it tethered.

(01:18:55):

You might find yourself floating away and go, "Oh, I'm floating away. Okay. Here are my feet." This is where squeezing, that containment lesson, can come in. "Here I am. Ah. These are my legs. I'm not on that surgical table, but I'm feeling these little bits of the surgery." Specifically, it's the pharmaceuticals that they give you.

(01:19:19):

I would also say if you have the ability to work with someone one-on-one, it is difficult to find someone trained in working with anesthesia and surgical trauma from a Peter Levine perspective. I have found that really good osteopaths are in some ways even better, in my experience, in working with anesthesia, because if they're working with the electromagnetic spectrums, other spectrums of energy, they can feel if a person is stuck still in that surgical anesthesia state. So a really good-trained osteopath can be a wonderful resource to have when working through this stuff. Yeah. I want to say, there's no clean-cut answer to this, and it comes down to you working with it, being with it, feeling it.

(01:20:18):

The other thing is the surgical anesthesia work, there's almost a little element of soul retrieval with this. Peter doesn't talk about his shamanistic viewpoints and such, but he has them. And you're literally, when you go under, your soul, it can float away. It can go into a different dimension. And that's the other thing is get all your pieces back into your body, and sometimes, that can also be this soul energetic level that can leave.

Seth (01:20:51):

Yeah. I've got a bit of experience with that. And one thing that came to mind is, yes, the importance of tethering, and that sometimes we actually need to be in that floaty dissociated

space. We don't want to try to come out of it necessarily, but we want to be there tethered, like Irene was talking about.

(01:21:14):

And another resource for that is music, and specifically shamanic drumming. So you could look up shamanic journey drumming, which is sort of a fast doom-doom-doom-doom-doom-doom-doom-doom, often for about 30 minutes. It could be interesting to put that on for yourself as a tether. That's something that it's consistent moving through your system, and you allow yourself to sort of go into this experience. Maybe it's a bit more floaty and uncertain, and you're not sure what's happening, and you just sort of let yourself be there, aware of this tether of sound that's keeping you connected to the here and now. Okay.

(01:21:57):

"My motivation toward work has changed. I had to stop launching and work back in October because of spinal surgery, and it was hard to accept that I needed to rest and pause, because I worked on sympathetic urgency and need since 14, and I'm now 59. I needed a month so I could sit up, but I now have no motivation to launch or market. I notice I'm resistant and unmotivated. And I'm not sure if it's because my daughter supported me with lots of social and logistics launching, but it was still very stressful. I need help, but I don't have money to hire, and my lack of motivation concerns me because I do need to make money."

(01:22:37):

So this is a tough situation because it sounds like a classic example of what happens when one shock comes along that unpacks the ability to really function, and then sort of everything that we've been holding gets kind of released, and we no longer can go back to the way that we used to do. So it sounds like that's the case here. You had this surgery which was this big shock to your system, and now you're in more of the freeze that has likely been in there your whole life. That's why there's this lack of motivation. I just don't want to do it. It's probably because your freeze got unpacked by the shock of that surgery.

(01:23:24):

So this is not unusual. Again, this is something that we see a lot. It's how it goes a lot of the time, especially when, like you say, you've been working on sympathetic urgency your whole life.

(01:23:37):

So I don't know how to address the need to make money piece. I can only know how to address the working with the nervous system and physiology piece. I understand the need to make money is a reality, but also, it really sounds like you're not at this point going to be able to go back to doing things the way you used to do. It sounds like you're in that camp of you've just been sort of introduced to what your actual capacity is, which is quite humbling, because when you're not in that sympathetic urgency, the capacity is very low, and there's actually all this freeze that's been there that now you're feeling.

(01:24:17):

So it may be that you need to, if possible, give yourself time to work with that freeze-y stuff. And now, this would be a good time to rewatch the early developmental trauma calls that I did with Jen, because all of those types of foundational building block approaches that we talk about in those calls is what I think is probably most relevant here. It's about learning to function from a place of authenticity and genuine capacity so that you can move forward.

(01:24:52):

Because a lot of that resistance and lack of motivation may be because it may be that your mind thinks you just, "Okay. I have to go back to doing what I was doing," and your system's not letting you, because it's like, "Uh-huh. We can't. We can't. We can't function like that anymore."

(01:25:06):

That's what happens when we have this kind of experience where there's a surgery or a breakup or an illness, and then we just lose our ability to be functional with our freeze. The freeze becomes non-functional, and then we have to build our foundations from that place of reality.

(01:25:24):

So I'll encourage you to go listen to those calls and all the ways we discuss to slowly build your capacity, and learn to work from a place of authenticity. So it's going to involve a lot of titration. How can you start to discover a different way to do your work?

(01:25:44):

And it may be that at first, it just means you do a little bit at a time. The mindset of one step at a time can be very helpful when we're having to relearn how to do what we do. I'm sorry. It's a tough situation, but it is not uncommon. It happens. Irene, anything you want to add to that one?

Irene (01:26:05):

Yeah. And this may or may not be helpful, but having been around the surgical scene a little bit and hearing of people decline after surgery, I have a feeling that a lot of that decline is because they're still stuck in that anesthesia state.

(01:26:29):

And I'm just going to speak from personal experience, because I've had two anesthesia in the last two years. Three years. One, I had in 2021, I came out of that one fine. The last one I had was in August to have a piece of hardware taken out of my leg from a previous surgery, and the drugs they gave me were way more powerful than the surgery I had three years ago.

(01:27:03):

And like I said a second ago, I didn't fight with the anesthesiologist, but he was like, "We're going to give you this and this and this." There was a benzodiazepine in it and there was something else, and there was something. That was pre-anesthesia. And it took me a long time to actually get out of that low-lethargy state, and it was the osteopath that I was working with that helped me break out of that chemically-induced... It's like I was in a cloud.

(01:27:35):

But some things that one could do to help detox naturally is, of course, make sure your food, your diet, is clean. If you can practice the circadian biology things that I talk about in some of my interviews on YouTube, get your feet on the earth, get your skin into some sunlight, get

morning light, get evening light. Make sure that you're replenishing your body with minerals. Anything to just help the fluids of your body get healthier.

(01:28:12):

Because I'm pretty convinced that a lot of the surgical drugs that we get to go under are impacting our fluids. And I just remember, I don't know if you remember, Seth, it took me a long time to recover from that, and it was so different from the one I had had three years before, but it was a different anesthesiologist. It was a younger anesthesiologist, and I think he was being all fancy with his cocktails of drugs. Whereas the guy I had three years ago, he was old, but he was very old school, I think, and he kept it simple. He didn't load me up with a bunch of stuff before I went under.

(01:28:49):

Detoxing, we talk about the mineral zeolite. That can be helpful to get any of the icky chemicals that have been put into your system from that surgery. The other thing to be aware of is if there was any hardware put into your body, just make sure that there's no complications with that hardware, because that can also cause problems. I don't want to scare anyone here, but these are some of the things that people don't think about when they get implants, metal, titanium, these sorts of things, into their body. It can impact the system's ability to heal.

(01:29:24):

Okay. Last one. There was a question I caught, but I don't know where it is. It was from Rachel. They asked us, Seth, does it have to be drumming, that you mentioned? Or it could be any repetitive sound?

Seth (01:29:40):

It doesn't have to be drumming. That's just a traditional one. It could be anything that you're comfortable with. If there's a piece of music that you're really familiar with that makes you feel a lot of comfort, familiarity, that can be good.

(01:29:52):

I mentioned the shamanic drumming one because it's sort of a traditional thing that's used for that kind of experience, and that repetitive, simple rhythm is supportive of being in the trance state while also being aware of the sound, so.

Irene (01:30:09):

So again, I know we're going over time here, but if this is the person that asked the question, they said, "Yes, two titanium rods, tons of screws put in." So –

Seth (01:30:22):

That's a huge thing to adapt to.

Irene (01:30:24):

And you can't get that taken out, from what I know. I know with my knee patella reconstruction, they could take out the screws and wire that was in my knee. That's why I got this metal taken out of my leg last summer. But if you can't, this is where I would recommend getting some of that zeolite that we talk about, that can help move some heavy metals out of the body.

(01:30:52):

The other thing, and this is going to sound a little strange, and I don't have experience doing this, but how can you make peace with that metal? Kind of like those sci-fi films where you get the cyborg arm, it's like you've got to make it part of you.

(01:31:10):

And this might be a little more shamanic, a bit more prayer-based, but how can you accept this and have it be something that's helpful and work with it in that intentional way if you know that you can't get that hardware out, which is most likely the case? So, yeah.

Seth (01:31:33):

Before you do the last question, I just want to clarify one thing about osteopaths, because they can be super supportive, but it's important to know there's very different kinds. So the osteopaths that we are talking about, that have the ability to work at these much more subtle

energetic levels, are usually European-trained or Quebec-trained. I believe it's the sort of European School of Osteopathy.

Irene (01:31:58):

French. Yeah.

Seth (01:31:59):

The French School of Osteopathy. That's the tradition that has these much more subtle things. If you go to just an American-trained osteopath, it could be much more like a chiropractic thing from what I've heard.

Irene (01:32:11):

It depends. It depends. Some still have that. But again, osteopathic training, it's a four-year training here in Canada at least. It's not just a weekend workshop kind of thing, right?

(01:32:28):

And they also can manipulate. It's also different from biodynamic craniosacral. So they also are trained in craniosacral therapy and these other layers of working with the body, but yeah. The art of it was very much from the French and from European ancestry, the healing ancestry from Europe. And when you find a good one, they're really good, and they all work a little differently too, so yeah. But, yeah. Different from craniosacral.

(01:33:04):

Okay. Now, the last question. So, “once we have more capacity and embodiment and awareness, can other trauma release exercises like TRE, biodynamic breathwork, or EMDR be added? Or is it still too much forcing the body? Does it depend on which modality?”

(01:33:27):

So I'm going to add a little more to this question. So they asked, "Once we have more capacity, embodiment, and awareness, can other trauma release exercises help?" So I'm going to add one piece, which is we want to get to the point where we're experiencing natural trauma release without an added intervention. And as we grow our capacity and as we get more

awareness, that is in service of our body naturally taking out the beach balls from the swimming pool, to use that example.

(01:34:06):

Now, you might work with a practitioner to help move some of this along, and by that, I mean someone, as we mentioned a second ago, who is trained in, say, our methodologies here. What I have found is when we get into that world of organic release, we don't need these things necessarily.

(01:34:32):

Now, the one that could potentially offer some support is breathwork. There's nothing wrong with some breathwork practices, but if we're doing them to try to regulate, that won't work. Breathwork can be wonderful for expanding the lung capacity, feeling all these different parts where you can breathe into, into the ribs, into the front, into the belly, into the shoulders, but that alone typically isn't going to release trauma.

(01:35:05):

EMDR can be helpful if you're working on something very specific that is typically shock trauma-based. It is not recommended for early trauma. So again, yeah. Maybe there's an old memory of being bit by a dog when you were young and you're afraid of dogs, there's a phobia or something like that, and you know that you've got some pretty good capacity on, then that might be useful. Hypnotherapy can be useful once you have baseline regulation on board, but I don't recommend it before then.

(01:35:39):

Some people have found that TRE, bits of TRE, this is trauma release, can add a little push to the system. I have seen more experiences or situations where people have overused TRE, and the system gets into this instant shaking response that actually doesn't do anything at all. So again, it's like, "Could you use these?" You could, but it depends on the context. And you also don't want it to be the holy grail. You don't want to become dogmatic about it and be like, "I'm going to use this to get all these traumas out."

(01:36:18):

Do you have anything else to add to that, Seth? I think the other thing, this would fall into, sorry, people have been quite big into plant medicines, and microdosing, and using psychedelics. I have no doubt that those have a time and a place, but are you using them as just a little help as opposed to that's all that I'm using?

Seth (01:36:42):

Totally. Yeah. No, and I don't have much to add. I mean, TRE is an interesting one because it was developed specifically for shock trauma. It's possible if all one has is a shock trauma, and their body is just kind of repressed, and they don't know how to allow that shaking response to come through, then maybe that would be useful.

(01:37:07):

But the thing is, like Irene said, we want to build our capacity such that it happens organically without pushing on the system, and that is much more holistic and supportive of the whole being, so yeah. All the things that we might use, that might be used to release trauma, aren't really needed anymore once that starts happening organically.

(01:37:33):

And those other tools may be useful for other things, like breathwork can be part of exploring altered states of consciousness. The psychedelics, maybe you want to deepen your exploration of yourself. Sure. But it's more about expanding our consciousness, expanding our capacity with curiosity and by exploring different areas. It's not so much about doing this trauma work.

(01:38:03):

Someone asked, "Why not EMDR for EDT?" Well, think about a little baby. Will they be able to follow your finger as you're doing this? It's overstimulating. I have heard some talk that they're working on different approaches to using that for early trauma. But so far, from what we've seen, it tends to be just overstimulating. My practitioner, Ian, would sometimes do tiny bits of EMDR when I was working through my early developmental trauma as to support integration, but we're talking maybe two seconds. The tiniest little bit of bilateral stimulation was to support integration. So someone really has to know their stuff with EMDR if they're working with early developmental trauma. There's a lot of other things that will be much more useful.

(01:38:59):

All right. Well, that ended up not being short. I guess we're long-winded. Well, thank you all for being here. Thank you, Irene, thank you, Jen, thank you, Bonnie, and thank you to all of our wonderful students and alumni for being here, we really appreciate you. And we will see you next week for the final call or the final Q&A call of this round. Yeah.

Irene (01:39:25):

Thanks, everyone.

Seth (01:39:26):

Thanks, all.

Irene (01:39:27):

Thanks, Jen.

Seth (01:39:28):

Bye.