

## Schematized Recovery Packet

- 1) Introduction to the Schematized Recovery Packet
- 2) “Schematized Recovery”
- 3) “The Complete Picture” Schematic with six paragraphs (back)
- 4) “Deconstructing Insanity” Schematic with “A Crime Scene Reconstruction Inventory”
- 5) “First Aid for Adult Children” Schematic with “The Consciousness Process” and “Recovery Overview”
- 6) ACA Fellowship Text (The Red Book)
- 7) “Giving Memory Its Sting” (PowerPoint slide)
- 8) “The Sequence of Withdrawal” (PowerPoint slide)
- 9) “A Three Tier Model of Addiction and Recovery II” (PowerPoint slide)
- 10) “Letter to a Colleague”
- 11) “Six Essential Therapeutic Tasks” (optional) available at: [responsesidetherapy.com](http://responsesidetherapy.com)

## Additional Supplemental Items

- 1) Technical Insert
- 2) Staying Conscious, Sane and On Purpose
- 3) Unconsciousness Process (and the Essence of Conflict Addiction)
- 4) Questions and Considerations (for recovery)
- 5) Thumbnail “Bang”
  - Decoder Addendum
  - Late Edition

## Introduction to the Schematicized Recovery Packet

### Goal Directed Behavior/Teleological Draw/Star Trek Attractor Beam

Over the years a great deal of research has been done in psychology on goal directed behavior. One of the most significant findings about goal directed behavior is that a clearly articulated goal, that is kept “front and center”, will exert a teleological draw (like a tractor beam); things will line up to materialize the desired outcome or make the goal a reality. This is why it is so important to have a clear, precise description of the desired outcome in trauma recovery (**diffusion will create confusion**).

Two things are crucial in taking a “walk talk” to a good outcome (making the transition, page 354, BRB). The first is to get the “talk” right (an accurate description of traumatic etiology and its after-affects). The talk needs to accurately answer four questions; “What happened?”, “Where did it leave you?”, “What can you do to get better?”, “How will you know when you’re done?” (answers that re-solve the problem of how to; “Clear your head”, “Open your body”, “Rise above the demoralizing spirit of addiction”).

Secondly, the talk needs to spell out the steps to take that will result in dismantling and removing the post traumatic apparatus (habituated reactions) that keeps you in the repetition/retox/maintenance loop (detoxed and “unhooked”).

Remember, lousy (inaccurate) models of reality (sans trauma) lead to lousy (ineffective) practice which leads to lousy outcomes (no recovery draw, no progress [round and round, stuck in place, going backward], no success [except to stay stoned]).

### Something to Think About

Primary ontological security exists as an essence (a possibility). Very rarely does it exist as a concrete state of existence (materialization). Concretize the essence, make it really real.

All the work that went into creating the Schematicized Recovery Packet was done with a single purpose in mind: getting accurate answers to the four questions and then materializing the desired outcome (completing the transition):

- A cleared head
- A re-opened body
- A removal of spiritual oppression

Recovery consists of autoplastically re-adjusting a tightly wound, highly compressed system. Do it carefully.

## Schematized Recovery

(ACA Convention 2007, 2008, 2009)  
An unofficial adjunct to the ACA Fellowship Text

### Overview

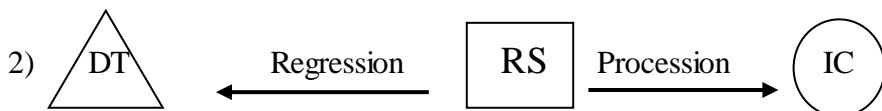
#### Recovery Procession From:

The Drama Triangle To: the Recovery Square (a fourth option) to: the Re-Occupy/Integrity Circle (re-opened, de-toxed, conscious, relaxed, back online in one piece) – the “Complete Picture Schematic”

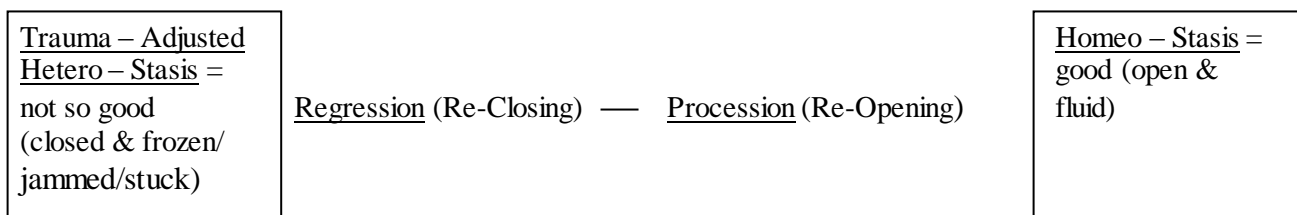
#### Chart Your Progression Through The Procession!

#### Back & Forth:

- 1) Karen Horney’s neurotic styles (adapted to trauma recovery)
  - moving against (aggression),
  - moving toward (placation/propitiation – passive aggressive),
  - moving away (openly, inwardly [internal retreat])



- 3) Regression/Procession/Stasis & Recovery



- 4) Chart your progression through the procession!

#### Re-Solving:

Seabaugh’s 14 problems of vulnerability, and repairing the wear and tear brought on by the stress and strain or resistance (the nuts and bolts of recovery, [pp. 627-28, ACA Text]. This includes “flipping” both “Laundry Lists” and zeroing out the ACA equation (ACA Disease Model [pg. xxvi, ACA Text]) using Appendix A as a re-orienting guide.

### Sequence of the Schematics:

- First – “The Complete Picture” (front and back – a comprehensive dissociative transactions analysis)
- Second – “Deconstructing Insanity” (with accompanying explanatory text of “A Crime Scene Reconstruction Inventory”) and with “The Other Laundry List” (victimizer standpoint) added in at 9 o’clock (to the right of “The Problem”), “The Solution” added in at far left of 12 o’clock (left of “The Basic Five”), and “The Flip-Side of the Other Laundry List” added in at 6 o’clock (to the right of “The Flip Side of the Laundry List”), descriptors of recovery and finish.
- Third – “First Aid for Adult Children” (staying on course with “The Consciousness Process” spelled out as an addendum to the schematic and the “Recovery Overview” a concluding synopsis)

# The Complete Picture

## Characteristics of an Adult Child

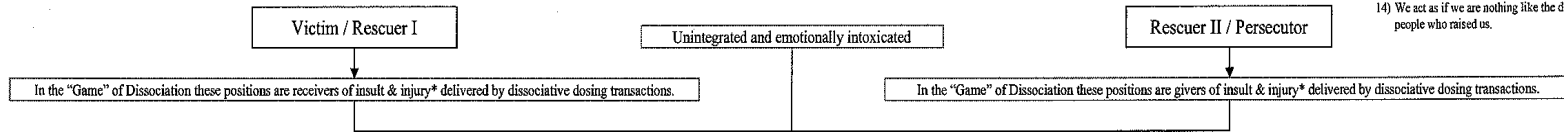
### The Laundry List

- 1) We became isolated and afraid of people and authority figures.
- 2) We became approval seekers and lost our identity in the process.
- 3) We are frightened by angry people and any personal criticism.
- 4) We either become alcoholics, marry them, or both, or find another compulsive personality such as a workaholic to fulfill our sick abandonment needs.
- 5) We live life from the viewpoint of victims and are attracted by that weakness in our love and friendship relationships.
- 6) We have an overdeveloped sense of responsibility and it is easier for us to be concerned with others rather than ourselves. This enables us not to look too closely at our own faults.
- 7) We get guilt feelings when we stand up for ourselves instead of giving in to others.
- 8) We become addicted to excitement.
- 9) We confuse love with pity and tend to "love" people who we can "pity" and "rescue".
- 10) We have stuffed our feelings from our traumatic childhoods and have lost the ability to feel or express our feelings because it hurts so much (denial).
- 11) We judge ourselves harshly and have a very low sense of self-esteem.
- 12) We are dependent personalities who are terrified of abandonment and will do anything to hold on to a relationship in order not to experience painful abandonment feelings which we received from living with sick people who were never there emotionally for us.
- 13) Alcoholism is a family disease and we became para-alcoholics and took on the characteristics of the disease even though we did not pick up the drink.
- 14) Para-alcoholics are reactors rather than actors.

### The Other Laundry List / The Opposite Laundry List

A Reaction Formation List; "It Will Never Happen To Me"

- 1) To cover our fear of people and our dread of isolation we tragically become the very authority figures who frighten others and cause them to withdraw.
- 2) To avoid becoming enmeshed and entangled with other people and losing ourselves in the process, we become rigidly self-sufficient. We disdain the approval of others.
- 3) We frighten people with our anger and threat of belittling criticism.
- 4) We dominate others and abandon them before they can abandon us or we avoid relationships with dependent people altogether. To avoid being hurt, we isolate and dissociate and thereby abandon ourselves.
- 5) We live life from the standpoint of a victimizer, and are attracted to people we can manipulate and control in our important relationships.
- 6) We are irresponsible and self-centered. Our inflated sense of self-worth and self-importance prevents us from seeing our deficiencies and shortcomings.
- 7) We make others feel guilty when they attempt to assert themselves.
- 8) We inhibit our fear by staying deadened and numb.
- 9) We hate people who "play" the victim and beg to be rescued.
- 10) We deny that we've been hurt and are suppressing our emotions by the dramatic expression of "pseudo" feelings.
- 11) To protect ourselves from self-punishment for failing to "save" the family we project our self-hate onto others and punish them instead.
- 12) We "manage" the massive amount of deprivation we feel, coming from abandonment within the home, by quickly letting go of relationships that threaten our "independence" (not too close).
- 13) We refuse to admit we've been affected by family dysfunction or that there was dysfunction in the home or that we have internalized any of the family's destructive attitudes and behaviors.
- 14) We act as if we are nothing like the dependent people who raised us.

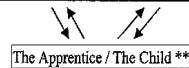


### Completing the Cycle of Violence

*Closing the Circle*

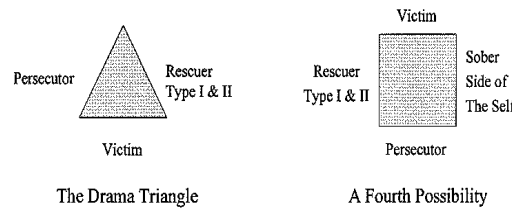
Positions in The Game of Dissociation

<b>Male Victim</b> • Overt Victim • Covert Victimizer	<b>Female Victim</b> • Overt Victim • Covert Victimizer
<b>Male Victimizer</b> • Overt Victimizer • Covert Victim	<b>Female Victimizer</b> • Overt Victimizer • Covert Victim

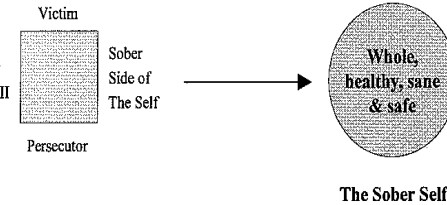


### Bringing the Family Drama to a Close

(Withdrawing from the Game of Dissociation)



### Completing the Recovery Process



## Characteristics of an Integrated Person

### The Flip Side of The Laundry List

- 1) We move out of isolation and are not unrealistically afraid of other people, even authority figures.
- 2) We do not depend on others to tell us who we are.
- 3) We are not automatically frightened by angry people and no longer regard personal criticism as a threat.
- 4) We do not have a compulsive need to recreate abandonment.
- 5) We stop living life from the standpoint of victims and are not attracted by this trait in our important relationships.
- 6) We do not use enabling as a way to avoid looking at our own shortcomings.
- 7) We do not feel guilty when we stand up for ourselves.
- 8) We avoid emotional intoxication and choose workable relationships instead of constant upset.
- 9) We are able to distinguish love from pity, and do not think "rescuing" people we "pity" is an act of love.
- 10) We come out of denial about our traumatic childhoods and regain the ability to feel and express our emotions.

### The Flip Side of The Other Laundry List

- 1) We face and resolve our fear of people and our dread of isolation and stop intimidating others with our power and position.
- 2) We realize the sanctuary we have built to protect the frightened and injured child within has become a prison and we become willing to risk moving out of isolation.
- 3) With our renewed sense of self-worth and self-esteem we realize it is no longer necessary to protect ourselves by intimidating others with contempt, ridicule and anger.
- 4) We accept and comfort the isolated and hurt inner child we have abandoned and disavowed and thereby end the need to set out our fears of emeshment and abandonment with other people.
- 5) Because we are whole and complete we no longer try to control others through manipulation and force and bind them to us with fear in order to avoid feeling isolated and alone.
- 6) Through our in-depth inventory we discover our true identity as capable, worthwhile people. By asking to have our shortcomings removed we are freed from the burden of inferiority and grandiosity.
- 7) We support and encourage others in their efforts to be assertive.
- 8) We uncover, acknowledge and express our childhood fears and withdraw from emotional intoxication.
- 9) We have compassion for anyone who is trapped in the "drama triangle" and is desperately searching for a way out of insanity.
- 10) We accept we were traumatized in childhood and lost the ability to feel. Using the 12 Steps as a program of recovery we regain the ability to feel and remember and become whole human beings who are happy, joyous and free.
- 11) In accepting we were powerless as children to "save" our family we are able to release our self-hate and to stop punishing ourselves and others for not being enough.
- 12) By accepting and reuniting with the inner child we are no longer threatened by intimacy, by the fear of being engulfed or made invisible.
- 13) By acknowledging the reality of family dysfunction we no longer have to act as if nothing were wrong or keep denying that we are still unconsciously reacting to childhood harm and injury.
- 14) We stop denying and do something about our post-traumatic dependency on substances, people, places and things to distort and avoid reality..

\* Note: Insult and Injury = Punishment, abandonment, conditional acceptance, conditional care

\*\* "Oh, No! These are my choices?"

### Completing the Circle (in the Cycle of Violence)

To understand how the Cycle of Family Violence is transmitted (from parents to children) it is necessary to identify and delineate all of the components of the inter-generational transfer of traumatically generated internal addiction and emotional intoxication. These are: repetition of dialogue (self talk and self recrimination), re-creation of scenes (the symbolic movies in the mind) and situations (with real-time "stand-ins" - the "Replacements") which together can be called "The Distractors", the recapitulation of emotions (feels the same) through the reconstitution of the biochemistry (internal uppers, downers, pain-killers and thought regulators) and reconfiguration of the body (held the same way), all of which is called the process of traumatic reproduction (Freud/Ferenczi). This results in a predictable dissociative forgetting which leaves a person numb, unconscious and stuck in the past.

Children who are caught up in the frightening, erratic, chaotic and demoralizing environment of a severely dysfunctional family are constantly searching for clues and indicators as to what their highly conditional "providers" demand and will tolerate in meeting the basic needs of the children. The children have no way of knowing that their caregivers themselves are relying on a confusing, hurtful, "superstitious" mix of sane and insane behaviors and beliefs about survival that was passed on to them. The beat goes on with one generation pounding its insanity into the next. In order not to go completely mad children have to dissociate or partially separate from their unbearable reality. The dilemma of dissociation is that traumatized people can't afford to forget what they do not want to remember. The memories of early trauma experiences represent how the world was, who to fear, and what must be done to maintain some degree of safety. Therefore, early trauma memories and emotions are always threatening to break through into consciousness. A dissociated person is preoccupied with dividing energy and attention into maintaining dissociation and attempting to live some kind of meaningful life in the present.

The Problem says we are "dependent personalities" who are "terrified of abandonment," and will "do almost anything to hold on to a relationship in order not to be abandoned emotionally". However we keep "choosing insecure relationships because they" match "our childhood relationship with alcoholic or dysfunctional parents." The "almost anything" we will do is to hold on to the "package deal" of dissociative living we were given in childhood in the not unreasonable belief that that is the best we can do. The form of the package deal follows Eric Berne's life game of "alcoholic". However, for adult children, Berne's variation of "dry drunk" is the best fit. As in all of Berne's games there are a series of moves by the players (transactions) that result in a "payoff".

In the "game" of dissociation there are two basic positions, victim and victimizer (persecutor). The victim may have a confederate, the earnest, "helpful", ineffective rescuing friend or pal (Type I Rescuer). The Type I Rescuer is essentially a victim waiting to happen. The persecutor may be disguised as a highly conditional rescuer - "I'll 'accept', 'love' you if and when" (Type II Rescuer). Of course the conditions can never be met and the Type II Rescuer can flip into the persecutor at the drop of a hat. The persecutor is the one who gives the insults and injuries that maintain dissociation (dissociative dosing transactions) while the victim is the one who does the receiving. A "successful" dosing transaction is one in which the insult and injury exchange leaves both (or all) the players in the game more absent than present (unconscious-stupified) and more there then (regressed) than here now, in other words, dissociated (hypoxic, hypercarbic, hypoglycemic).

Both victim and persecutor are terrified of abandonment. The victim is more obviously desperate and needy while the persecutor is so terrified of falling into the abyss of abandonment that the terror has been completely walled off. The only form of love or connection that can be tolerated is to be the one who punishes and abandons, to not be the one who is punished, neglected and finally abandoned. Children don't know they are targeted to become objects of addiction in the "game" of dissociation, that the adults will overtly and covertly force the children to accept (introject) their demands that they embrace the addict way of life. To put it bluntly the demand from adults to children in a conflict-addicted family is "we need you to be a player (addict) to cope with and endure our hyper-dependency syndrome". The forced introjection is the means-whereby the "game" of dissociation is transmitted intergenerationally along with the twisted, superstitious justification / rationale for continuing the family's insanity.

The solution is to use the 12 Steps to eject the introjects and stop the "game", to regain personal integrity, to become sober and sane. The essential point is the traumatic etiology of addiction - stop the trauma / re-trauma; stop the dissociation / addiction. The word addiction comes from the Latin "to say to", to say yes to a strong habit (denial). Essentially recovery is a matter of turning that around and just saying "No!"

## The Complete Picture

# DECONSTRUCTING INSANITY: BRINGING YOURSELF BACK ONLINE

## THE ONE PERSON PROCESS OF RECOVERY: ONE HISTORY, ONE BODY, ONE SELF

### The Basic Five (Daily Needs)

1. Adequate Respiration (Body Ventilation)
2. Adequate Hydration, Nutrition and Elimination
3. Adequate Rest and Restorative Sleep
4. Adequate Temperature Regulation (Internal and External)
5. Adequate Stimulus Level (Avoiding Stimulus Overload and Stimulus Deprivation – pain, fear, panic, despair, and exhaustion)

### Six Essential Recovery Tasks

- 1) **Recognition**  
This task centers around our recognition of dysfunction including physical responses, cognitive problems and interpersonal difficulties in social situations and with significant others. The fellow traveler's task is to encourage this vital recognition of the signs of distress in a way that builds trust and creates the sense of unity needed to continue in the recovery process.
- 2) **Recollection**  
This task involves uncovering and embracing the hidden dissociated parts of the self. Because of traumatic conditioning, these hidden parts of our selves perceive, evaluate and respond automatically as independent operating systems. Each system holds a specific set of memories, beliefs and related habits that maintain dissociation. The fellow traveler's task is to provide assurance that recovery is possible and the return of memories and sensation will not be self-destructive.

- 3) **Disobedience**  
The basic belief in a traumatizing family is that the practice and support of destructive behavior by adults should be tolerated and accepted without protest by the children. Children are threatened, punished, and coerced into keeping the adults' behavior secret. They also incorporate the adults' dissociative and destructive patterns into their own being. Disobedience includes breaking these habits of avoidance and denial and relinquishing our beliefs about maintaining destructive behavior. This may require detoxification from addiction to exogenous substances and the deconditioning of habitual body tension and cognitive hypervigilance. The main subtask is to disobey irrational authority by challenging the belief that we need to continue these behaviors.

- 4) **Retaliation**  
The motivating force being inhibited is the talionic response (direct eye for an eye retaliation for abuse [Reik]). This instinctive rage toward people who have caused us harm has been forcefully inhibited and is often directed back toward the self (retroflexion - going against the reflexes) or displaced onto others. Unblocking this energy and safely expressing the talionic response opens us up to feel other inhibited emotions and accelerates the process of mourning and grief. The primary subtask is learning to discriminate hostile introjects that have been pounded in and swallowed whole from the people who first caused us to live in fear and to stop displacing rage onto symbolic stand-ins in the present. The fellow traveler can support the differentiation process and the appropriate expression of talionic rage which strengthens reality testing about expected retaliation.

- 5) **Separation**  
The task of separation is to distinguish between what has been termed "me and not me" (Sullivan). This includes recognizing the internalizations and confusing beliefs of people who hurt us, as well as considering the concept of locus of control and the possibility of independent thought and action.

- 6) **Independence**  
This final task centers around completion of reflective grieving (mourning the loss of possibilities, opportunities and self-actualization), learning to repair ourselves, and mastering developmental stages that may have been missed or poorly negotiated. The fellow traveler can assist in the overall process by encouraging the development, rehearsal and implementation of effective social skills and self-determined actions that increase self-esteem and self-worth. Most importantly, completion of this task establishes the capacity for genuine intimacy and successful present-directed, goal-oriented living.

### ACA 12 Steps

1. We admitted we were powerless over the effects of alcoholism or other family dysfunction, that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understand God.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked God to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and, when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God, as we understand God, praying only for knowledge of God's will for us and the power to carry it out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to others who still suffer, and to practice these principles in all our affairs.

### Bill W.'s In-Depth "True Self" Inventory

Bill, in a letter to a friend, wrote about deepening AA's moral inventory to focus on what he called psychic damage: "... It may be that someday we shall devise some common denominator of psychiatry – of course, throwing away their much abused terminology – common denominators which neurotics could use on each other. The idea would be to extend the moral inventory of AA to a deeper level, making it an inventory of psychic damages, relying in conversation episodes, etc. I suppose someday a Neurotics Anonymous will be formed and will actually do all this." He later suggests the inventory be about "actual episodes: inferiority, shame, guilt, anger" so they could be believed in the mind and their power reduced. The true, non-neurotic self could then emerge out of hiding. (Letters with commentary reprinted in Fitzgerald, R (1995), The Soul of Sponsorship, Hazelden, Center City, MN, pp. 41-42.)

Pg. 626, ACA Fellowship Text

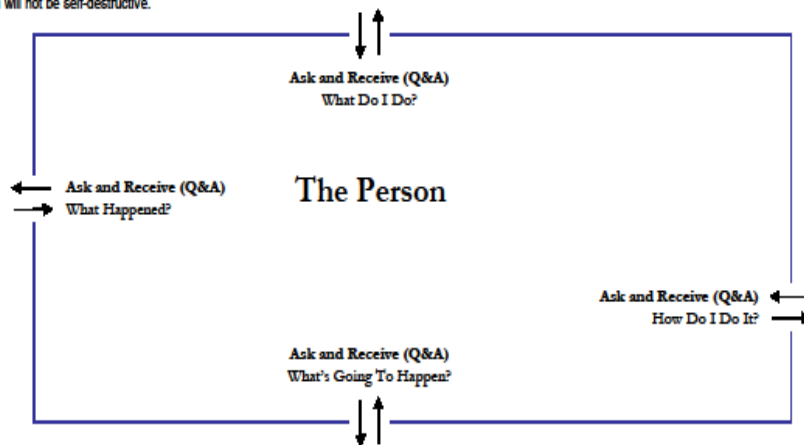
### Characteristics of an Adult Child

#### The Laundry List

1. We became isolated and afraid of people and authority figures.
2. We became approval seekers and lost our identity in the process.
3. We are frightened by angry people and any personal criticism.
4. We either become alcoholics, marry them or both, or find another compulsive personality such as a workaholic to fulfill our sick abandonment needs.
5. We live life from the viewpoint of victims, and we are attracted by that weakness in our love and friendship relationships.
6. We have an overdeveloped sense of responsibility, and it is easier for us to be concerned with others rather than ourselves; this enables us not to look too closely at our own faults, etc.
7. We get guilt feelings when we stand up for ourselves instead of giving in to others.
8. We became addicted to excitement.
9. We confuse love and pity and tend to "love" people we can "pity" and "rescue".
10. We have "stuffed" our feelings from our traumatic childhoods and have lost the ability to feel or express our feelings because it hurts so much (Denial).
11. We judge ourselves harshly and have a very low sense of self-esteem.
12. We are dependent personalities who are terrified of abandonment and will do anything to hold on to a relationship in order to not experience painful abandonment feelings, which we received from living with sick people who were never there emotionally for us.
13. Alcoholism is a family disease; we became para-alcoholics (codependents) and took on the characteristics of that disease even though we did not pick up the drink.
14. Para-alcoholics (codependents) are reactors rather than actors.

#### The Problem

Many of us found that we had several characteristics in common as a result of being brought up in an alcoholic or dysfunctional household. We had come to feel isolated and uneasy with other people, especially authority figures. To protect ourselves, we became people-pleasers, even though we lost our own identities in the process. All the same we would mistake any personal criticism as a threat. We either became alcoholics (or practiced other addictive behavior) ourselves, or married them, or both. Failing that, we found other compulsive personalities, such as a workaholic, to fulfill our sick need for abandonment. We lived life from the standpoint of victims. Having an over developed sense of responsibility, we preferred to be concerned with others rather than ourselves. We got guilt feelings when we stood up for ourselves rather than giving in to others. Thus, we became reactors, rather than actors, letting others take the initiative. We were dependent personalities, terrified of abandonment, willing to do almost anything to hold on to a relationship in order not to be abandoned emotionally. Yet we kept choosing insecure relationships because they matched our childhood relationship with alcoholic or dysfunctional parents. These symptoms of the family disease of alcoholism or other dysfunction made us "co-victims," those who take on the characteristics of the disease without necessarily ever taking a drink. We learned to keep our feelings down as children and kept them buried as adults. As a result of this conditioning, we confused love with pity, tending to love those we could rescue. Even more self-defeating, we became addicted to excitement in all our affairs, preferring constant upset to workable relationships. This is a description, not an indictment.



### The 12 Promises

If we are painstaking about this phase of our development, we will be amazed before we are half way through.

1. We are going to know a new freedom and a new happiness.
2. We will not regret the past nor wish to shut the door on it.
3. We will comprehend the word serenity.
4. And we will know peace.
5. No matter how far down the scale we have gone, we will see how our experience can benefit others.
6. That feeling of uselessness and self-pity will disappear.
7. We will lose interest in selfish things and gain interest in our fellows.
8. Self-seeking will slip away.
9. Our whole attitude and outlook upon life will change.
10. Fear of people and of economic insecurity will leave us.
11. We will intuitively know how to handle situations which used to baffle us.
12. We will suddenly realize that God is doing for us what we could not do for ourselves.

Are these extravagant promises? We think not. They are being fulfilled among us - sometimes quickly, sometimes slowly. They will always materialize if we work for them.

### Amends Process:

*The amends process begins with the self, with restoration and restitution for the self-punishment, neglect, and abuse that was done intentionally or inadvertently.*

### Note:

The Laundry List and The Problem emphasize slightly different aspects of dysfunction and they are best read together for a more complete picture of post-childhood reactions to dysfunction in the home.

DECONSTRUCTING INSANITY:  
BRINGING YOURSELF BACK ONLINE  
THE ONE PERSON PROCESS OF RECOVERY:  
ONE HISTORY, ONE BODY, ONE SELF

**Thoughts On Inside Service (In-Reach)**

Service in general is taking action to support and encourage adult children as they make the transition from fragmentation and regression to integrity and present-day thinking and doing. This means being ever-mindful of the requirement to 12<sup>th</sup> Step ourselves to wholeness and emotional sobriety. As more and more of the self wakes up we are increasingly able to go within and find, comfort and heal the hurt, vulnerable and frightened "inner" children, who have been lost, hidden or frozen in time and place, and bring them up and forward to the here and now. This completes the reunion of the divided self.

*Cling to the thought that, in God's hands, the dark past is the greatest possession you have - the key to life and happiness for others. With it you can avert death and misery for them.*

Pg. 124, Alcoholics Anonymous (AA Big Book)



***A Crime Scene Reconstruction Workshop***

**CONDUCTING A CRIME SCENE RECONSTRUCTION INVENTORY**

(How to Make an Inventory of Bio-Psychic Damage)

*or*

**Critical Incident Debriefing and Trauma Recovery**

(Developing a Self-Help Trauma Treatment Training Manual)

## Overview: A Crime Scene Reconstruction Workshop

### Background:

At a 1989 dissociative disorders conference in Chicago the keynote address was given by Michael Durfee, an LA physician who investigated child homicides, not an easy job. With more than a little gallows humor his talk was called "How to Make a Multiple" (multiple personality disorder – now dissociative identity disorder). If you want to deliberately create a profound dissociative reaction in someone how would you go about doing it? Essentially our workshop will answer the question "How do you make an adult child?" and then what do you do to heal and integrate the adult/child division? (What do you do to unmake an adult child?).

At an earlier conference a paper was presented (Smith, 1987) in which a definition of trauma was provided. Prior to this everyone agreed that being traumatized was not a good thing and after-trauma consequences were debilitating; however, no one was exactly sure how to define what it was that happened to which everything else was then post.

The entry on trauma in Campbell's Psychiatric Dictionary noted that the term had been so over-used and misused that it had ceased to be useful as a descriptive concept. In the paper (Post Traumatic Stress and the Loss of Ontological Security) the definition of trauma was pegged to the action of the "flight or fight" (sympathetic) nervous system. Trauma was defined as the maximum arousal of the "flight or flight" nervous system by pain or the threat of pain (fear). It can't be pushed any higher no matter what happens.

Ellert Nijenhuis and his colleagues in a 1998 article "Animal Defensive Reactions as a Model for Trauma-Induced Dissociative Reactions" looked at this "pedal to the metal" reaction from the point of view of animals in the wild focusing on "circa strike" literature or "around the time of the strike". The strike in this case is when the lion jumps or "strikes" the antelope. When the definition of trauma and the strike idea are put together we can call a trauma event a "trauma strike". The trauma strike is the basic unit of measurement for determining how much personal damage is done as a result of living in what is primarily a self-perpetuating trauma delivery system which is a way of describing a major family dynamic in our dominator/competitor culture.

Bill W. (True Self Inventory – bottom right corner of the schematic) said it might be possible to devise some common denominators of psychiatry that neurotics (adult children) could use with each other (what in the 1980s was called co-counseling). The common denominators are the trauma strikes and their cumulative, debilitating after-effects, or what in the First Step is referred to as the "effects of alcoholism and dysfunction" over which we have no power and that make our lives unmanageable (loss of control). The descriptive versions of these effects are the Laundry List traits, and as The Problem says they are the "result" of being raised in an alcoholic/dysfunctional family.

There are experimental, empirically measured laboratory equivalents of trauma strikes where the sympathetic nervous systems of animals have been deliberately raised to the top, and they can be used to illustrate how to make an adult child. These experiments are openly acknowledged and not hidden and denied as they are in an alcoholic/dysfunctional family.

Three well-known groups of lab experiments over the years have been used to explain post-trauma reactions; learned helplessness, neophobic perseveration, and experimentally induced neurosis (Kolb, 1987). Learned helplessness (Seligman, 1975) involved dogs that became immobilized after being shocked and would no longer jump over a small barrier to escape the electric shock. Neophobic perseveration (Mitchell, et al., 1984, 1985) involved mice in a T-maze that would stop alternating (going first down one arm of the maze and then the other) after being shocked at the top of the T, at the choice point, and would keep going down the chosen arm even when they were shocked again at the end of the arm. Experimentally induced neurosis (various experimenters) (Anderson, et al., 1939, Watson, 1954) involved the whole barnyard (cats, rats, sheep, etc) where the animals were put in a "damned if you do, damned if you don't" situation and went nuts. In humans

the “Stockholm Syndrome” (Graham and Rawlings, 1991) has received a great deal of attention. This is where hostages bond with their captors or approach the person(s) who terrorize them. These studies can be called 3P Psychology – the psychology of Paralysis, Perseveration and Pathological attraction (3P’s).

Seligman (1975), in writing about learned helplessness, was fortunately very clear when he uses the phrase “traumatic electric shock” and in specifically stating the dogs were traumatized in the experiments. Animals in these God-awful lab experiments receive a set number of deliberate trauma strikes to bring about the 3P’s. There’s no debate about experimental cause and effect. For children who receive trauma strikes in an abusive environment it’s another story. The strikes are generally hidden and the after-effects are ignored and denied. The Laundry List characteristics and The Problem detail the effects of trauma in the home.

The Basic Five in the upper left corner of the schematic are the daily needs children should have adequately met as their birthright. The extent to which a predictable and stable daily adequacy routine for all the Five Needs cannot be maintained is the extent to which the childhood barriers and impediments originally designed to defend and protect us are still operating. These are the problems the Six Essential Tasks are meant to address and solve.

For each animal in these experiments there is a certain trial, which varies by the individual animal, where a decision and conclusion is reached that all is hopeless and nothing will ever change and no effort will succeed in making things better. After a few trials in the learned helplessness experiments, for instance, the dogs sprawl out and give up. They are confused and demoralized. The AA Big Book uses the memorable phrase “pitiful and incomprehensible demoralization”. This fits both dogs and people who have been subjected to repeated inescapable trauma. For them it’s better to forget, go unconscious and just mark time. It is these decisional/conclusional moments that need to be uncovered so we can re-conclude and re-decide in the hopeful sustaining context of the 12 Steps. The Fourth Step then becomes a thorough inventory of demoralization – actual episodes of bio-psychic insult and injury.

Roger Watson (1954) in discussing his experiments on experimentally induced conflict in cats noted that many cats are totally dependent on humans for the satisfaction of some basic needs and “in this aspect, the adult cat can be compared with the human child.” Both the experimenter and the parent have the power to preserve or destroy the cat or the child respectively even though the animals and children can “no more evaluate our intentions in this regard (preservation by authority – parentheses added) than they could evaluate our possible intentions to destroy them” if they screw up and disobey irrational authority.

This view and expectation of authority is crucial in considering the Second Step. It’s almost as if rational outsiders need to come in and shut down the experiment as was done in Zimbardo’s prisoner/guard study when the whole thing had gotten away from both the experimenters and the experimental subjects. The outsiders would tell the experimenters/caregivers? in our laboratory of origin to go to their rooms or a neutral corner and then tend directly to the injured and frightened children. They would demonstrate that a somewhat Higher Power could take steps that would restore us to sanity, consciousness and wholeness. We could then proceed from there in rethinking our concept of God.

All of our act-outs and act-ins, are re-enactments (van der Kolk, 1989), trauma repetition compulsions. We compulsively re-create the same insane social arrangements in which we are abandoned, abandon others and most importantly abandon ourselves in a hopeless, never ending cycle of struggle and fail, seeking oblivion while desperately trying to keep a foot in reality at the same time.

By contrast, the impulse in children is to maintain adequacy or better with the Basic Five as a matter of course. That’s what instincts and our nervous system are designed to do. The Six Essential Tasks are meant to uncover the history of accumulated hurts and fears that reveal why a person couldn’t and still believes she or he can’t keep what Karl Menninger (1963) called “the vital balance”. The 12 Steps can then be used to show how this can be done and how the “how” can be put into practice by walking through the broadened and

deepened re-parenting process. Or put another way, recovery is to a great extent a matter of breaking the learned, traumatically conditioned habit of basic inadequacy.

In natural and man-made disasters first responders are sent to the scene to treat and stabilize the injured and to treat or prevent for shock (to prevent the dangerously low blood pressure that is the hallmark of shock). This is done even for people who are not physically injured because the emotional jolt alone can cause the blood pressure to plummet (fainting, passing out). Children learn to over-ride and avert this collapse with a surge of adrenaline and internal pain-killers which are frequently boosted with outside chemicals. Lab animals and soldiers become hardened after repeated trauma strikes. For every trauma event there is an increase in resistance. This “robbing Peter to pay Paul” arrangement can only go on for so long before we pay the piper and reach the breakdown/exhaustion phase of Selye’s (1976) “general adaptation syndrome”.

At critical incidents like the Minnesota bridge collapse or the Virginia Tech shooting trauma teams also work to prevent the development of full-blown post trauma reactions. As children we should not have had to endure injury and harm in the home. But because that was a given we should have at least had emergency medical technicians (EMTs) and trauma teams coming through the door after every critical incident to treat our injuries and provide critical incident debriefing. The damage done in a traumatizing family is a crime and this is why our workshop will show how to uncover our hurt and wounded inner children and make our 9<sup>th</sup> Step amends by providing a new level of re-parenting. This may start by becoming our own loving paramedic and might involve an extended period of rehabilitation in which we give the wounded self the comfort, care and support that was tragically absent in our homes.

#### **The Actual Workshop:**

Omer G. and Marty S. will go through the schematic and connect the dots between Bill W’s In-Depth inventory and the First Step effects of alcoholism and family dysfunction and the Laundry List traits which are the tangible results of being raised in an alcoholic/dysfunctional family. Omer will describe how our traumatically conditioned habits of dissociation that were supposed to protect us and keep us safe now prevent us from taking proper care of ourselves and allow us to heal. He will then discuss how the Six Essential Tasks can be used in the context of the 12 Steps to uncover the self-defeating habits and beliefs so they can be acknowledged and released, and the positive aspects of recovery can begin to materialize. (The Six Essential Tasks outline a recovery process in which the focus is on; recognizing the signs of distress and dysfunction, uncovering and embracing the hidden vulnerable self, breaking the habits of distortion and denial and affirming that it’s possible to say “No” to insanity, disinhibiting the nervous system and ejecting the introjects, acknowledging the need to detach from the past and consider the possibility of becoming an individual, completing and forgiving the past, recovering and accepting the disavowed self, regaining self-worth and becoming happy, joyous and free).

Jim S. will then go through the 3P Psychology experiments and make the all-important link between these openly acknowledged, non-debatable effects of trauma and the unacknowledged, denied effects taught in our home-based laboratories.

Tracy L. will explain how the body powers up and prepares itself for an imminent dangerous encounter and how with every trauma event, there is a corresponding increase in resistance (armoring and hardening). She will also explain how, when the system is pushed into running high and hot for too long, the body becomes Hypoxic (low oxygen), Hypercarbic (too much carbon dioxide) and Hypoglycemic (blood sugar depletion). These 3H’s are the physiological basis for dissociation (when you’re spaced out you don’t think very well).<sup>1</sup> Ultimately the three H’s rest on the three D’s: Debility, Dependency and Dread (Lemov, 2005).

Don C., based on his experience at a youth crisis shelter, will cover how Critical Incident Debriefing techniques, used at acknowledged disaster scenes can be adapted for use in retroactive debriefing, particularly with the child or children within.

Debbie M. will interact with the workshop participants to reach and reconnect with the hurt, frightened and vulnerable parts of ourselves hidden in our protective prison behind a wall of dissociation and denial. She will use her experience to communicate with the participants about how to establish the trust needed to encourage the cautious, uncertain and perhaps mistrustful and angry parts of the self, hiding in protective seclusion, to risk coming up and out into the light of day. This of course will require that we prove to the hidden self we have the willingness, knowledge and support necessary for healing and we can be trusted to provide the soothing, comfort and care needed to make the body and our surroundings a place to come home to.

**Summary:**

The Basic Five are the non-negotiable demands of reality - they must be met at a minimal level in order to survive. In an alcoholic/dysfunctional family we are forced to accept a grossly inadequate system and schedule of supply and provision (taught and learned insanity). Bill W. wrote at the root of every disturbance is an unhealthy dependency and a consequent unhealthy demand. We internalize the unhealthy (insane) demands of a confused and confusing culture and then demand of ourselves that we make do and turn a sow's ear into a silk purse; that we accept the habits of basic inadequacy. With the Twelve Steps we can come to reject unhealthy demands and withdraw from false dependencies and replace them with adequacy and sanity (reality based hope).

<sup>1</sup> Sandor Ferenczi, a contemporary and confidant of Freud, developed a theory of trauma that Freud strongly criticized and the psychoanalytic community ignored. In this entry from his clinical diary (10 January 1932 [1988]) Ferenczi clearly indicates the importance of hypoxia and hypercarbia in creating dissociation.

*In moments of great need, when the psychic system proves to be incapable of an adequate response, or when these specific organs or functions (nervous and psychic) have been violently destroyed, then the primordial psychic powers are aroused, and it will be these forces that will seek to overcome the disruption. In such moments, when the psychic system fails, the organism begins to think.*

*An example: someone, in childhood, is sexually assaulted by a brutal giant. For a time all mental powers remain fully active, all possible effort is made, though in vain, to ward off the attack (struggling, screaming, for a short period even conscious emotions of hate, thirst for revenge, etc.). But when the weight of the man pressing down on the child becomes more and more unbearable, and especially when the attacker's clothing unrelentingly blocks the child's air passages, causing extreme shortness of breath, all sensation of pressure, of genital injury, any knowledge of the cause of the painful situation and its antecedents disappear; all available psychic force is concentrated on the single task of somehow getting air to the lungs. Yet even this task becomes progressively more and more difficult. Evidently as a result of carbon dioxide poisoning, violent headaches and a sensation of dizziness develop. (In the analytic reproduction, as well as in the nocturnal reproductions in nightmares, this stage is accompanied by a typical Cheyne-Stokes respiratory pattern. The muscles are tensed to the maximum, then relaxed completely, the pulse is accelerated and irregular.) pg. 6*

## References:

- Anderson, O. D., Parmenter, R., Liddle, H. S. (1939). Some cardiovascular manifestations of the experimental neurosis in sheep, *Psychosomatic Medicine*, Vol. 1, No. 1, 93-100.
- Ferenczi, S. (1988) *The Clinical Diary of Sandor Ferenczi*, Harvard University Press, Cambridge.
- Fitzgerald, R. (1995). *The Soul of Sponsorship*, Hazelden Press, Center City Minnesota.
- Graham, D. and Rawlings, E. (1991). Bonding with abusive dating partners: dynamics of Stockholm Syndrome in dating violence, ed. Levy, B., *Dating Violence*, Seal Press, Seattle
- Kolb, L. C. (1987). A neuropsychological hypothesis explaining post traumatic stress disorders. *American Journal of Psychiatry*, 144:8, pp. 989-995.
- Lemov, R. (2005). *World as laboratory: experiments with mice, mazes, and men*, Hill and Wang, New York
- Menninger, K., Mayman, M., Pruyser, P. (1963). *The Vital Balance*, The Viking Press, New York.
- Mitchell, D., Kolezar, A. S. & Scopatz, R. A. (1984). Arousal and T-maze choice behavior in mice: A convergent paradigm for neophobia constructs and optimal arousal theory. *Learning and Motivation*, 15: 287-301.
- Mitchell, D., Osborne, E. W. & O'Boyle, M. W. (1985). Habituation under stress: Shocked mice show nonassociative learning in a T-maze. *Behavioral and Neural Biology*, 43: 212-217
- Nijenhuis, E., Vanderlinden, Y., Spinhoven, P. (1998). Animal defensive reactions as a model for trauma induced dissociative reactions, *Journal of Traumatic Stress*, Vol. 11, No. 2, 243-260.
- Reik, T. (1962). *Masochism in Sex and Society*, Grove Press, New York
- Seligman, M. E. P. (1975). Depression and learned helplessness. In Rosenhan, D. & London, P. (eds), *Theory and Research in Abnormal Psychology* (2<sup>nd</sup> Ed.), Holt, Rinehart and Winston, Inc, New York.
- Selye, H. (1976). *The Stress of Life*, (rev. ed.), McGraw-Hill Book Co., New York.
- Smith, M. R. (1987). Post-traumatic stress and the loss of ontological security: overcoming trauma-induced neophobia in adult children of alcoholics, in B.G. Braun, ed., *Proceedings of the Fourth International Conference on Multiple Personality/Dissociative States*, Chicago.
- Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry*, Norton, New York
- Watson, R. E. (1954). Experimentally induced conflict in cats, *Psychosomatic Medicine*, Vol. XVI, No. 4, 340-347.
- van der Kolk, B. (1989). The compulsion to repeat the trauma, *Psychiatric Clinics of North America*, Vol. 12 No. 2, 389-410.

# First Aid For Adult Children

## Keeping It Together On The Road To Happy Destiny

Staying Open To Experience  
Protecting the Brain (and Body)\*  
While Coming Back Online

\* *Bodymind* (Dychtwald, 1986)

### Quick Intervention

- STOP** (spinning)  
*Slow down - Breathe*

- DETRANCE** (stop watching the mind movies)

Engage all five senses:

- *Look at some things (actual)*
- *Make a noise*
- *Eat a peach*
- *Smell some cinnamon*
- *Pat your face*

- THINK**

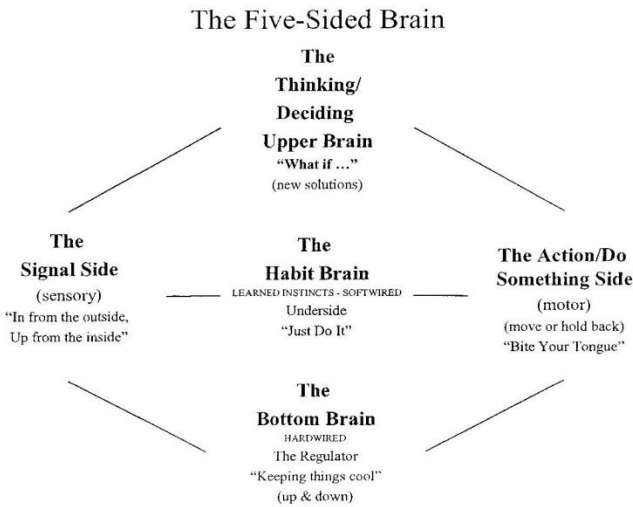
- *This is now and not then*
- *This is here and not there*
- *This has already happened*
- It is not:
  - Happening now
  - About to happen

- KEEP GOING** (yes, you can)

- *Move*
  - *Make another choice*
- You don't have to:  
– Fight, Flee, Freeze or Fail (Shock)



- You don't have to:  
– Keep recreating/re-acting paralysis, perseveration, and pathological attraction (trauma binding, the crazy familiar, the Stockholm Syndrome)



If we jam, overload or deprive the body/mind the Bottom Brain will apply the brakes to slow the system down or will over-ride the rest of the brain and bring the whole system way down (the spacey, woozy shock continuum).

*In other words the Bottom Brain will finally “crash the system” to save it.*

### What To Do

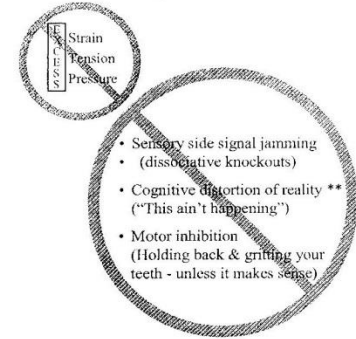
#### Paramedics & EMTs (emergency care)

- 1) *Clear the airway*
- 2) *Stop the bleeding*
- 3) *Protect the wound*
- 4) *Treat for/prevent shock*

#### Adult Children (recovery)

- 1) *Maintain adequate respiration (relaxed, even breathing)*
- 2) *Maintain circulatory sufficiency (keep the fuel & air flowing)*
- 3) *Stop the battering (inside & out)  
“We are the wound”*
- 4) *Get off the Up/Down, hop till you drop, bipolar rollercoaster*

### It Is Possible (The Ideal)



\*\* The Vulnerable Self of the Adult Child of an Alcoholic (Seabaugh, 1987)

### Coming Back Online

(and avoiding the neophobic kickback)  
*Bring the senses, the actor/thinker and the buried memories back around carefully and gently (respect the inner child).*

### And Now For The Goodies

(The ACA Promises)

1. We will discover our real identities by loving and accepting ourselves.
2. Our self-esteem will increase as we give ourselves approval on a daily basis.
3. Fear of authority figures and the need to “people-please” will leave us.
4. Our ability to share intimacy will grow inside us.
5. As we face our abandonment issues, we will be attracted by strengths and become more tolerant of weaknesses.
6. We will enjoy feeling stable, peaceful, and financially secure.
7. We will learn how to play and have fun in our lives.
8. We will chose to love people who can love and be responsible for themselves.
9. Healthy boundaries and limits will become easier for us to set.
10. Fears of failures and success will leave us, as we intuitively make healthier choices.
11. With help from our ACA support group, we will slowly release our dysfunctional behaviors.
12. Gradually, with our Higher Power's help, we learn to expect the best and get it.

## **First Aid For Adult Children**

Keeping It Together On The Road To Happy Destiny

**Note:**

A short summary explaining the schematic will be added to this space and placed on the ACA Convention website.



## Withdrawing From the Trauma-Drama Game

### The Consciousness Process

(Re-minding, Re-remembering, Re-habiting  
or reversing  
Amnesia, Analgesia, External Location)

#### Markers of Progress/Completion (Bio-Electrical & Hydro-Mechanical)

1. The muscles stretch out.
2. The knots pop open.
3. The spine decompresses.
4. The pain goes down.
5. The nerves fire.<sup>3</sup>
6. The blood flows.
7. Air goes to the brain.
8. Buried memories come back
9. The body relaxes.<sup>4</sup>

Homage to Elvis<sup>1</sup>  
"I'm all seized up!"

<sup>1</sup> Re-scrunchification ("Let's Twist Again!")  
Repetitive Seizing Syndrome (Self-Stim)

**Bio-Psychic Autoplastic  
Re-Adjustment Back to a  
Pre-Trauma State (the  
Healthy, Protesting Infant)<sup>2</sup>**

#### Corporeal Expansion Components (Body Relaxation)

- a. The throat, jaws and mouth ease open (vocal capacity)
- b. The shoulders come down (breathing, spinal decompression)
- c. The abdominals unclench (breathing, neural/vascular flow)
- d. The pelvis descends (n/v flow, non-defensive posture, spinal decompression)

<sup>2</sup> Recovery Reward = No More "Ow, That Hurts!"  
Continuous C-Fiber Stimulation (Default to Crash)

<sup>3</sup> It's the Deadening Instinct, not the Death Instinct  
(Freud's Mistake) Numb not Dead

<sup>4</sup> Repression = Motoric Inhibition (Fenichel)

### The Consciousness Process (Summary)

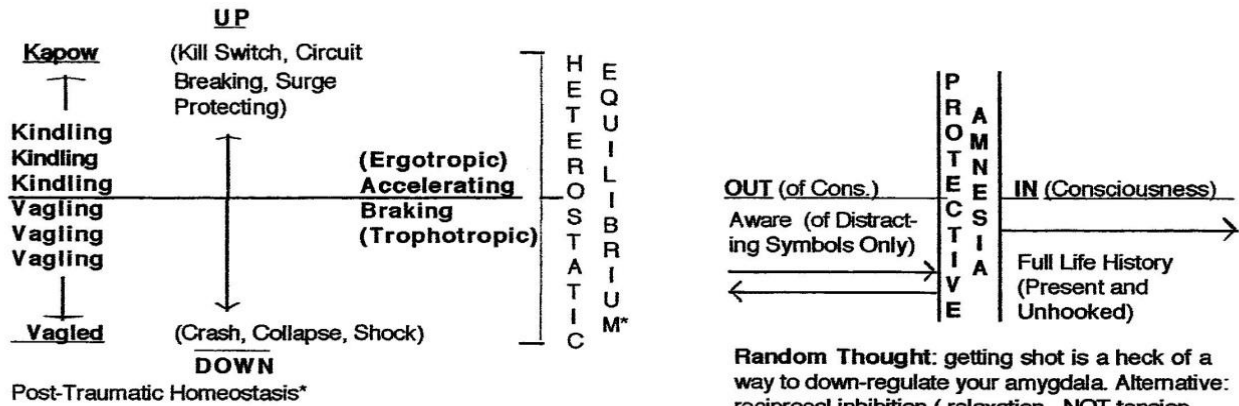
- De-symbolize the Psyche (Dispelling the Fog of Awareness)
- Re-cognize (Re-mind) w/ Madeleine Clarity
- De-stress the Machine (w/o Wrecking it!) (Spinal/Vascular Decompression, Bio-chemical Detoxification)
- Re-presentation without Devastation (Resistance is Electrical!)  
(The Return of Response-ability w/ a Disinhibited Nervous System)

#### The Endo-Addict's Dilemma

"I gotta rest. No, I gotta cop and keep going."

No matter how you look at someone with a re-trauma habit, you'll see a troubled spirit with a highly distressed body and brain.

## The Physics of Trauma and Recovery (Four Prepositions)



It's All About Intention Where You Put Your TEA (Time, Energy, Attention) "Your TEA is Strong, Grasshopper."

### Crisis Management vs. Maintenance & Protection (Internal Preservation) (Enpressive/Expressive Antagonism: The War Within)

When the pain, fear and confusion that come with post-traumatic attempts to manage present reality (what is) while simultaneously trying to dissociate from the effects of what was (the hurtful past) become intolerable (overloading), traumatized people will revert (default) to habituated, dysponetic security operations (the family's familiar coping schemes) in a desperate effort to stay up and not go under (the spell of the symbols). They are seeking to avert a "psycholeptic crisis" (Janet, Baynes), a reality surge overload.

The rest and restoration part of the brain competes with the thinking/ engaging/ deciding/ acting side for all available TEA. If the fight goes on for too long, the system will default to collapse (double default). That's addiction.

### **WAR**

Closed/Contracted

Enpressive

Aware

The Pandora Effect: Just a Glimpse (of Our Past) & **SLAM!**

### **PEACE**

Open/Expansive

Expressive

Conscious

The Pygmalion/ Galatea Process: Unfrozen, Thawed Out, Back From the Deadened

### Guiding Concepts of Developmental Trauma Recovery

- SBD- Stop, Breathe, Dismantle (The Defenses)
- Unlocking the Interlocked (Learned) Instincts (Breaking the Habit of Reality Avoidance [Denial])

- No More P.F.C. (Pain, Fear, Confusion)
- Healing & Liberating The Wounded and Hidden Vulnerable Self (Coming Back Online)

All this really amounts to: sit down and remember your life. The unfinished, unacknowledged past is always being forcefully re-presented, pushing for resolution and completion. Let the past catch up. The point of letting go and coming to: a stretched out, realigned, decompressed and de-stressed body + liquidation (of the past) by memory (Janet) = an untroubled self.

NOTE: De-bottlizing (proper realigning) can be painful and scary and can trigger efforts to prevent forward progress, a counter-push to return to the familiar "safe" post-traumatic adjustment (re-bottlization). De-bottlize slowly and carefully (reassure the inner children). Keep in mind that at no point in the recovery process do we want to recreate the anaerobic, hypoxic states of panic, desperation and hypoglycemic exhaustion (reinforce the dissociation). Uncover the trauma trigger history without generating a "smackback" (vortex).

### Liberation (Looks Like)

Open to Experience

(Unblocked neural transmission, energy flow)

Non-Defensive

Relaxation w/ appropriate vigilance)

Associated

(Present/available body/brain ventilation, aerated, O<sub>2</sub> everywhere)

Ontologically Secure

(Liberated from the bondage of the past)

**Being: Conscious and Secure**

**Here, Now and OK**

# Recovery Overview\*

## Smith's 1<sup>st</sup> and 2<sup>nd</sup> Laws of Addiction

### Smith's 1<sup>st</sup> Law of Addiction:

Dry drunk is first, substance abuse is later.

### Smith's 2<sup>nd</sup> Law of Addiction:

Technical sobriety is first, emotional sobriety is later.

Substance abuse is an endo-mimetic condition (sympatho-mimetic, para-sympatho-mimetic, opio-mimetic, benzo-GABA-mimetic) and is constructed on existing endogenous processes (internal uppers, downers, pain killers and thought regulators [stop, start, and focus]). If substance abuse has not entered the picture, then things can be simplified to the following: internal intoxication is the problem, endogenous (emotional) sobriety is the solution.

\*Addendum to The Consciousness Process 12/08/10

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The Consciousness schematic and the Recovery addendum delineate basic trauma adjustment/recovery re-adjustment processes and dynamics that can be incorporated into any theoretical/therapeutic/recovery framework. Endogenous sobriety is essentially the restoration of sanity and the recovery of consciousness.

To summarize:

- (a) The primary post-trauma addiction is endogenous dependency which may or may not evolve into endogenous/exogenous dependency.
- (b) The Consciousness Process lists a number of universal recovery goals that would be part of any successful healing process. These concrete biological markers can provide consistency in measuring and evaluating therapeutic progress and outcome.
- (c) The Consciousness Process offers a clear direction for healing without triggering somatic neophobia (fear of relaxation and going off guard; fear of dropping or dismantling the defenses).
- (d) Two trauma conditioned fears, post-traumatic thymophobia (fear of feeling) and somatic neophobia are crippling barriers to recovery that can be safely deconstructed through careful and systematic uncovering (deconditioning somatophobia).

ACA Fellowship Text (The Red Book)

# Giving Memory Its Sting

## *Tracing the Sources of Pain\**

- Muscles and trigger points
- Sphincters and the gut
- Stress and strain in the spine
- Organ damage

\* Continuous Activation of Pain Fibers (C-fiber re-stimulation)

\* Androclesian School of Medicine (“Pull out all the darn thorns!”)

# Sequence of Withdrawal I

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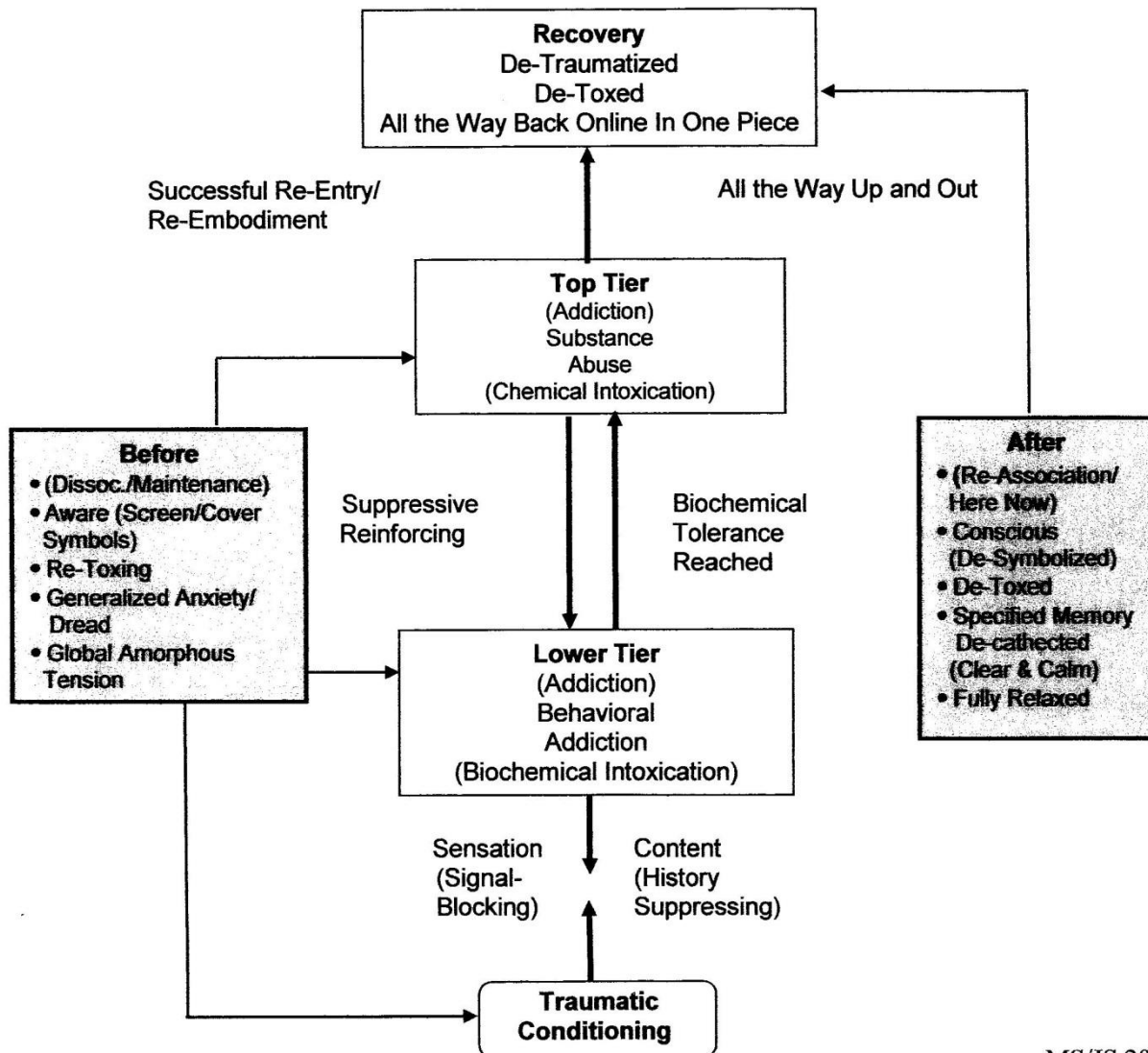
- Physical withdrawal  
(flexor withdrawal)
- Emotional & sensory withdrawal  
(biochemical retreat from reality)
- Cognitive withdrawal  
(a retreat from conscious attending and conscious knowing)

Conscious / Unconscious

## Crash to save

*The purpose of recovery, in a practical sense, is to reverse the protective sequence of withdrawal, to withdraw from withdrawal and become whole, alive and complete.*

## A Three-Tier Model of Addiction and Recovery (II)\*



MS/JS 2012

In recent years investigators have discovered biochemical “underpinnings” for both “emotional” intoxication and physical intoxication. Below the top tier of chemical dependency is a bottom tier of biochemical addiction requiring management and treatment.

This schematic diagrams the relationship and interaction between “behavioral/process addictions” (gambling, etc.) and auxiliary chemical dependencies, and spells out the markers of a successful recovery.

### Summary

Unblock your head and straighten out your body. The means whereby are all available (the model, monitors, metrics, and methodology, [with a verifiable finish]).

\* Following “A Two-Tier Model of Addiction” Handout 32nd Annual CAADAC/CFAAP Conference 2012

## Letter to a Colleague Concerning the Mechanisms of Release and Recall

Martin R. Smith

Recently I and several other people interested in reversing and healing the after-effects of trauma have been having success with an approach to trauma recovery I have been working to refine for a number of years now. The approach, Response Side Therapy, is an expansion of Marge Toomim's Active Biofeedback geared directly to the treatment of post-traumatic conditions in people who were traumatized in childhood. Response Side Therapy was first introduced in a *Journal of Humanistic Psychology* article (Fall, 1993, Smith and Jones). Since that time I've put my time and effort into making it a reliable, measurable (verifiable) and most importantly, safe and effective way to dismantle the post-traumatic adjustments people make to protect themselves in a consistently unsafe environment, and then to assist them in reaching a state of primary ontological security (Laing's beautiful vision). The restoration of ontological security is the conceptual framework of the therapy and the goal of recovery. Practically, the basic idea is that you tend to the contracted and compressed trauma-conditioned/trauma-adjusted body first (response side) and the stimulus side (the dissociated trauma history) will emerge in the process. The following paragraphs from an article at the Response Side Therapy website ([responsesidetherapy.com](http://responsesidetherapy.com)) I believe will give you a good overview of the therapeutic process:

The idea for guerrilla recovery comes from a series of papers presented at several conferences focusing on trauma-induced dissociation. They are foundational papers tracing the development of an ontological therapy (Smith and Jones, *Journal of Humanistic Psychology*, 1993) designed for the effective treatment of people who are neophobically perseverating in a familiar cycle of trauma and shock characteristic of people who live in what R. D. Laing called a state of primary ontological insecurity.

Laing's description of ontological insecurity as a progressive loss of relatedness to the self and others ending in chaotic nonentity parallels a description of a descent into compensatory



shock following the maximal arousal of the sympathetic nervous system by pain. People who experience violence as children in the nuclear family, as in an alcoholic home, are trapped in the most exquisite and despairing double-bind one can endure — they are dependent on people who have caused them to lose a sense of security at a primitive level. Children who are abused by their caregivers are driven out of the most precious home they will ever have — their bodies.

The purpose of ontological therapy is to assist traumatized people in going back home: to re-inhabit their physical being from which they were driven by thoughtless acts of violence perpetrated by people who were violated themselves as sacrifices on the altar of cultural insanity that we erect when we forget we are connected to one another by our common humanity. When we are dissociated from ourselves by trauma, we see the world in Buber's alienating categories of them and us. When we are able to work back through the divisive consequences of trauma and reconnect the numbed body with the dissociated lexicon of brutality, we emerge as a fully feeling being capable of making rational choices, which brings a sense of primary ontological security and the possibility of relating to others in an open, satisfying way (from *Guerrilla Psychology and Liberation Therapy*).

The following workshop outline explains Response Side Therapy in clinical terms:

### Two Therapeutic Ideals in the Treatment of PTSD

Martin R. Smith, MEd

This workshop, which was scheduled to be presented in Austria at the 2006 Biofeedback Foundation of Europe Convention, summarizes the basic approach and purpose of Response Side Therapy.

The purpose of this workshop is to introduce and discuss two therapeutic ideals in the treatment of chronic PTSD in adults who were abused as children, and to explore how treatment protocols may be designed to reach these ideals. The two

ideals are 1) "no tension except tonus" and 2) "no arousal except by reality" (is it real or is it Memorex?).

The first ideal focuses on the problem of pain produced by hyper-contraction and body compression and the need for thoroughness in relaxing the body armor. The goal of "no tension except tonus" is to reach a level of relaxation in both voluntary skeletal muscles and the smooth muscles of the alimentary canal so there is no excess tension.

Because relaxation in a hyper-tense person is associated with a loss of control and a feeling of being endangered, Marjorie Toomim's active biofeedback approach, with its emphasis on the underlying issues of dependency, trust and control, will be used as a model for therapy. The presentation will address the problem of distinguishing between the pain of letting go and holding on and what George Whatmore called dysponesis, or the misuse of energy, particularly as it refers to over control and the expectation of psychophysical collapse. Close attention will be given to relaxing the muscles and sphincters in the alimentary canal, the fear of involuntary expression, and the loss of motor inhibition.

Reaching the goal of "no arousal except by reality" depends upon a careful uncovering of the layered defense system found in PTSD. The layers are arranged according to Pavlov's order of conditioned stimuli. First order stimuli are the actual memories of abuse that evoke the strongest restimulation of panic, fear and rage. Second order stimuli are associated phobias, obsessions, dreams, and taboos, while third order stimuli are the worries and anxieties that beset everyone on a daily basis. Second and third order stimuli are used as screening material to cover and hold down first order memories. They hopefully stimulate enough arousal to stay above the deep despair that is at the heart of PTSD. Techniques will be presented for using biofeedback to safely guide the uncovering process by "dosing" the integration of traumatic memory.

Survivors of childhood trauma have a profound lack of trust. They mistrust their abusers and those who allowed the abuse

to take place. To stay safe they generalize the mistrust and stay on guard with everyone they encounter. The constant struggle by abuse survivors to keep repressed memories of abuse below the screen material creates considerable resistance, what Toomim called "going 90 miles per hour with the brake on". Therapeutic efforts to uncover the defenses can cause an increase in resistance with an increase in painful compression and contraction in an attempt to get back on guard (The "Jo-Jo Response" : a negative reinforcement system – "Boy, that almost broke through my defenses!"). This increase in pain can be disorienting and cause a regression in time and place. It is crucial in these situations to assist the survivor in discriminating *now* from *then* and *here* from *there* and to recognize the emerging memories of injury and hurt are not evidence of danger in the present. Reorienting procedures for anchoring the disoriented person in the present will be described.

Workshop participants are invited to share their ideas and experiences in achieving the therapeutic goals introduced in this workshop and to discuss ways to develop even more effective protocols for treating survivors of childhood abuse.

### **References:**

Dychtwald, K. (1977/86). Bodymind. Los Angeles, Jeremy P. Tarcher

Janov, A. and Holden, E.M. (1975). Primal Man. New York, Thomas Y. Crowell Co.

Menninger, K. et al (1963). The Vital Balance, New York, Viking Press

Smith, M.R. (2005). Marjorie Toomim: "A Remembrance"  
*Biofeedback*, (33) 2, 77-78

In describing her use of biofeedback and psychomotor re-education in the treatment of trauma-engendered dissociative conditions Marge wrote that she focused on three underlying psychodynamic issues: dependency, trust and control. It's possible to take these core issues and construct an ontological question children ask themselves: "Can I trust those on whom I depend for survival to control my internal and external environment so that I am and remain safe and secure?" If the answer is "no", or a highly conditional "yes", then children know that they're in trouble.

Perhaps the most profound failure in the modern era (post-Wundt and post-Freud) has been the failure of psychiatry, psychology, religion, philosophy and academia in general to isolate and accurately assess, identify, and measure and then acknowledge the sheer amount of coercion, force and violence that is used to socialize children and to control them after they reach adulthood (and to fully grasp the after-effects of such concentrated brutalization on the human self-system). The ontological question can be used to correct that failure and to construct a methodology for reversing the terrible consequences that come from the use of force and violence by authority to establish and maintain socio-personal control.

The following passage from Adult Children: Alcoholic/Dysfunctional Families, page 623; (2006) cites a crucial modification Hans Selye made to his general adaptation syndrome and links it to Marge Toomim's recognition of paradoxical flattening (the ANS antagonism between sympathetic acceleration and protective parasympathetic braking/neural inhibition [or going 90mph with the brake on]):

Hans Selye (1980), in an update of his general adaptation syndrome, wrote that the alarm stage could be divided into two phases: the shock phase and the countershock phase. In the shock phase, which he does not distinguish from the initial trauma phase, he lists the various signs of injury: "tachycardia, loss of muscle tone, decreased temperature, and decreased blood pressure." (p. 129) This is followed by the countershock phase which is "a rebound reaction marked by the mobilization of [the] defensive phase." He adds that "most of the acute

stress diseases correspond to these two phases of the alarm reaction.” (p. 129) In the resistance stage that comes after the alarm reaction, there is a “full adaptation to the stressor” with “an improvement or disappearance of symptoms” and “a concurrent decrease in resistance to most other stimuli.” (p.129) This is a great description of dissociative denial and mirrors Marge Toomim’s findings about paradoxical flattening (Toomim & Toomim, 1975). Exhaustion, collapse and death follow if the stress continues unabated.

The thing that is important in this paragraph is Selye’s use of the term *shock* following emergency up-regulation of the body (alarm). This is not an idle, metaphorical use of a precise medical term. Shock is a condition of inadequate tissue perfusion to the brain. He lists the markers of shock, tachycardia etc., that can result in collapse (fainting/coma). Selye emphasizes that most acute stress diseases correspond to the shock/countershock phase.

I’ve come up with an operational definition of trauma (it’s in the 1993 JHP article), that makes it possible to count the number of trauma events a person has endured (and suppressed) and to determine when resistance has occurred (armoring, dissociation, neural inhibition [signal jamming], effective suppression). Trauma can be defined as the maximal arousal of the sympathetic nervous system by pain or the threat of pain. Whether by active abuse or malignant neglect, if a child’s nervous system has been peaked by endangerment or harm and has been forced into a compensatory collapse, then the child has been traumatized. That is the event to which everything else is then *post*.

Carl Rogers wrote that in a person, who is open to experience, environmental stimuli would be relayed through the nervous system without distortion by any defense mechanism. This too can be turned into a question: what can happen to a person that would make it necessary for the nervous system to be closed to the experience? I believe repeated trauma events or trauma “strikes” is one answer.

Arthur Janov and Michael Holden were quite specific in explaining how our nervous system works to protect us from overwhelming pain/alarm signals. Here's an excerpt from a paper I presented that summarizes their work:

The work of Janov and Holden (1975) may help to shed more light on the process of repressing painful feelings resulting from childhood trauma. Janov makes an important distinction between "consciousness" and "awareness." Consciousness is a state of the organism, not a brain phenomenon alone. Awareness is a moment-to-moment process which always has a content. Janov writes that when content is directly related to subconscious processes, there is consciousness. When content is unrelated and only symbolically derived from the subconscious, there is only awareness. Awareness denotes disconnected thought processes while consciousness denotes when those processes are fully connected. For Janov, mental illness is an altered state of consciousness. "Painful realities are automatically and reflexively withheld from consciousness by certain structures of the brain..." (p. 2) "Unconsciousness represents a breakdown in the integrative capacities of the brain..." (p. 3) When the integrative system is overwhelmed by the blocked pain of early trauma, it becomes shunted into alternate cerebral pathways rendering the person, in that sense, unconscious. "Curing mental illness means altering consciousness so that awareness and consciousness merge rather than diverge as they do in neurosis and psychosis. This means changing the integrative relationships within the nervous system. Without that basic and profound change, I submit, there can be no cure for mental illness." (p. 5)

Janov continues that the reticular activating system supplies the "energy" of feeling and when it is disconnected from higher centers, this energy is experienced as "amorphous tension." Only certain areas of the cortex can control the activity of the reticular system. One of these is the frontal cortex. The limbic system, situated between the cortex and reticular system, integrates input from both the frontal cortex and the reticular system. Janov notes that a good "fronto-limbic connection" can stop the reticular activation. Conversely, childhood pain, stored in the limbic system can only be

defused by a frontal connection. Thus, childhood trauma is always pushing to get through to conscious awareness while the frontal- limbic connection is waging a war to keep the pain repressed.

This “closing”, surge-protecting/signal blocking function of the nervous system is a straightforward process. Its basic structure and component parts have been understood for decades (Melzack and Casey’s pain-gating theory, the work of Guillemin, Schally and Pert on endorphins and endogenous painkillers, the seminal research of Cannon and Papez on alarm arousal). The paralyzing, debilitating effects of attempting to “out-run” and hide from pain, alarm, anxiety and despair (and traumatic content) have been examined and dissected from the time of Freud and his circle, up to his revisionists: Fromm, Horney, Sullivan, Dollard and Miller, and continuing with the existential-humanists: Laing, May and Maslow, on to the present with the work at Saybrook, the AAPB and the emerging critique of the APA’s nosological stranglehold with its book of fiction, the DSM (I can imagine that deep down Rogers would want to toss out the whole manual). Freud’s most loyal disciple, Sandor Ferenczi, even had emergency equipment in his office to use in case one of his patients went into shock.

Penfield noted that he felt a great sense of relief when he realized the brain elaborates upward, going from the simple to the intricate. What has been consistently missed over the years in dealing with the confusion of contending theories and their practical implications, and in trying to make sense of the mountains of research, is the essential simplicity of the defensive process of shutting down and going offline. The brain elaborates upward and default is always down. If the neocortex can’t come up with and implement the best (or adequate) solution to reality demands, the brain will default to rote, habituated, inflexible and subconscious “security operations” to meet the demands. If the “habit brain” fails to “fix” the situation, the brain stem will over-ride the upper brain activity and throw the circuit breaker (the vagus nerve will discharge, the blood vessels will dilate and the person will drop to the floor – the bottom brain will crash the system to save it).

In practical terms (the only terms that ultimately matter in recovery) Ed Wilson's brilliant use of the flexor withdrawal reflex to explain trigger point formation and perseveration can be expanded into a model that both explains the trauma necessitated sequence of "withdrawing from reality" and the reverse sequence of re-opening to experience and coming all the way back online (of safely moving the disavowed life experience – the trauma and trauma adjustment/trauma accommodation history – back into consciousness).

This uncovering process requires a careful removal of the covering/screening material (Janov's awareness symbols) and an equally careful "unjamming"/disinhibition of the blocked pain/alarm signals, so that the hidden, sequestered and vulnerable, terrified "vital child" part of the self can come up and out.

There are two components of dissociated experience, content and sensation, and there are there five stages of re-association:

- 1) dissociated/symbolic (start)
- 2) emotive disclosure
- 3) dis-embodied recitation (content without sensation)
- 4) embodied recitation (this is hard at first; stages two and three can jump back and forth)
- 5) conscious, neutral, linear narration (the covering symbols have been removed and the covered life history has moved from the habit brain storage area up into cortical consciousness – the bottled-up, amorphous tension of suppression, Janov's state of awareness, has been permanently discharged and the system is relaxed and unguarded – Laing's state of primary ontological security)

To get back to the flexor withdrawal model and to start moving to the technical question I have for you about neural inhibition and muscular de-contraction – there is a point to all this foundation building! – I'll explain how the instinctual retraction of a limb, to get it out of harm's way, can be expanded into a model of dissociation, re-association, and full recovery from childhood trauma.



In a limb that is defensively withdrawn (when a hand is pulled back from a hot stove), the acidic waste products built up during the activity are removed by the blood after the emergency is over, and the limb is relaxed. Children raised in a hostile, unpredictable, reactive and perpetually endangering environment, with no exit, have bodies that are constantly braced and never relax except when they are exhausted, knocked out or chemically anesthetized (the markers of PTSD).

As Ed Wilson detailed in his monograph, a constantly stressed muscle will protect itself by encysting the waste products in a knot (trigger point) much like an oyster forms a pearl. These painful knots send signals to the spinal cord attempting to get into the neural traffic traveling to the brain. The best outcome would be for the signals to reach the neocortex and for the rational, analytical part of the brain to arrive at, and carry out a course of action that successfully resolves the pain producing, anxiety provoking situation.

For children trapped in a social environment that is endangering, neglectful and non-responsive (to safety/security needs), pain/alarm signals come from all over the armored, contracted body. Only the most urgent signals receive undivided cortical attention.

A considerable amount of the pain signals coming from the contracted musculature is blocked at the cord and put on hold. The signals are rebounded back to muscles with the message to protectively "splint" the pain-producing sites by re-contracting the already braced areas, and a non-resolving, reverberating pain circuit is maintained. It's no wonder that the body of a traumatically dissociated person who is employing a countless number of distracting symbols to cover and screen the first order memories of trauma, is locked in an agonizing state of amorphous tension.

The basic example of the flexor withdrawal reflex is the withdrawn limb. This can be extended to a turning away of the body to avoid harm and injury. The extreme limit of protective physical withdrawal is the fetal position. The only option beyond complete physical withdrawal is a biochemical retreat from reality – the "surge and cascade of 'inner drugs'" that accompany the experience of extreme duress and forces a retreat into

symbolic distraction and dissociative amnesia. The “inner drugs”, internal uppers, downers, pain-killers and thought regulators, are what make it possible for a traumatized child to stagger up off the mat (Selye’s resistance) and “play hurt” until exhaustion or traumatic repetition/re-enactment compulsions close the show for good.

Reversing this “withdrawal from reality” or “withdrawing from withdrawal”, re-opening the body and coming all the way back to complete consciousness and systemic relaxation (no tension except tonus), can be called a flexor relaxation model of recovery (awareness to consciousness, tension to relaxation).

Aldous Huxley said the brain acts as a “reducing valve on reality”. It seems he was right. Art Janov and Michael Holden examined the gate closing possibilities at the top and bottom of the brain (frontal-limbic, reticular system). Ed Wilson looked at signal blocking much further downstream at the main trunk line (the spinal cord).

The most important place for neural inhibition is the synaptic cleft itself where the neuro-transmitters inhibit nociceptive signals in the nerves closest to the pain production sites. The most obvious place to make an effective therapeutic intervention is the actual locations around the body where the pain is coming from (the actual sites where the pain of compression, injury and damage is being generated). Even though authors like Janet Travell, David Simons and Bonnie Prudden have exhaustively studied and mapped out trigger points locations and their referred pain patterns and even though comprehensive charts for surface EMG placements are available, theorists, researchers and practitioners have been remarkably unthorough in locating and mapping contributing pain sites and rigorously checking to see if their interventions are actually reducing and eliminating nociceptive stimulation and re-stimulation.

The reason this Androclesian approach to therapy is so important (“locate and pull all the darn thorns!”), is that by easing and eliminating the problems at their source (icing, warming, stretching, soothing) the sum total of signals pressing for registration, recognition and action would be dramatically reduced and the need for suppressive, defensive action would

be equally reduced. Ideally, there would no longer be distortion in the nervous system and there would be a clear channel to and from the brain (a complete openness to experience). Objectively, the muscles would be de-contracted and unknotted, the spine decompressed, the nervous system disinhibited and the trauma history would be fully conscious and decathected (no wallop). Overall the system would be de-pressurized.

Children raised in a traumatogenic environment are situationally dependant on those who pose the greatest threat to their survival and ontological well-being. They are forced to acquiesce to the reality avoidance demands of their providers and accept the meeting of their basic needs in whatever way and on whatever schedule it is given. Traumatized people require the assistance of trustworthy others to uncover, confront and break free of the internalized, irrational demands from childhood and then discover they can "trust their gut" to make the choices that lead to "the good life". They learn that they can love and care for themselves and are finally able to answer their ontological question in the affirmative.

Carl Rogers knew about biofeedback directed therapy and wrote something to the effect that his ideal would be to enter a person's domain so carefully that "the needle doesn't move" (this was in a paper I found during a visit to "the Center for the Study of the Person" years ago – unfortunately, it's buried somewhere in my den so I can't give you the title). It is in keeping with this spirit of carefulness that I ask the question about neural disinhibition and muscle release at the end of the following short letter I put together some time ago (at last!). The recovery process can be completed without answering the question. However, given the power of the suppression process, the volatility of the uncapped up surging emotions, and the amount of ontological hurt that needs to be soothed and healed, anything that adds a degree of control is important:

Dear \_\_\_\_\_ ,

Here's the letter I put together that lays out the background for the question at the end of the letter.

The reason I am writing to you is to see if you can provide an answer (or direction to an answer) to a thorny question I have encountered about neural transmission.

First the background:

(Starting with the previous paragraphs on Art Janov and Michael Holden)

Charles Kelley, in a *Journal of Humanistic Psychology* article (Fall 1972), pointed out that a significant problem with Janov's Primal theorizing was his failure to adequately acknowledge his debt to Reich and the importance of the body. Primal pain is to a considerable extent the cumulative amount of nociceptive signals surging up from a chronically contracted and compressed body. These signals are jostling and screaming for attention from a beleaguered and overwhelmed neocortex (looking for conscious ego control with an adequate solution).

Signal suppression and blocking at the spinal cord and at the limbic system create a logjam resulting in a subcortical standoff between ascending excitatory and descending inhibitory energy. Exogenous chemical assistance (substance abuse) and periodic, compulsive pressure reducing act-outs can offer temporary relief. But, as Paul Revere and the Raiders put it, "the kicks just keep getting harder to find".

What I've discovered is that the logjam can be un-jammed and the signals brought through in a more orderly, manageable way when the pain is reduced locally through extensive icing and very careful stretching and range of motion exercises, done in conjunction with body soothing and body comforting interventions. I called this response-side intervention (JHP Fall 1993). When you can't make sense of the stimulus complex plaguing a person, you can always bring relief to the body. This is particularly true when you use biofeedback as a guide, like Marge Toomim's active biofeedback (Smith, 2005).

The problem is that relief and relaxation usually trigger a back-on-guard response. Therapeutic progress is perceived as a threat. This evokes what Freud referred to as secondary anxiety: unfocused anxiety that occurs when the defenses are about to fail. Automatic (habituated) efforts to reassert

protective denial and dissociation are what keep people from moving from Janov's state of awareness to consciousness.

All of what I've shared so far is in preparation for posing my question. When the ascending exhibitory energy pushes through the fronto-limbic block and energy and content emerge into consciousness (affect + memory = completed experience), the inhibiting musculature actually moves. Motor *en*pression gives way to motor *ex*pression. This is quite evident in the muscles of vocalization and the supporting apparatus of breathing.

Otto Fenichel recognized, years ago, that Freudian repression was motoric inhibition and Peter Levine's running bear seems to bear that out (bad pun!). This is Reich's expansive self and Marge Toomim's release of the brake (Toomim's research on ANS antagonism, "going ninety miles an hour with the brake on"). Sullivan notes the marked muscle tension in catatonics, and any number of body-oriented theorists has called attention to the dramatic muscle release in abreactions. I saw this as well at the Primal Institute.

What I can't figure out are the connecting mechanisms. How and why do the holding-back muscles' stretch receptors activate and release the contractions at the precise moment symbolic content pops through the fronto-limbic block into the clarified memory of consciousness? Bioelectrical surge and hydro-mechanical release happen simultaneously. What are the mechanisms and processes linking body expansion/release and conscious recall?

I would very much appreciate hearing your thoughts on the problem.

## REFERENCES:

Fenichel, O. (1953), Organ libidinization accompanying the defense against drives; in the Collected papers of Otto Fenichel (First Series), Norton, NY

Kelley, C. R. (1972), Post-primal and gender character: A critique of Janov and Reich; *Journal of Humanistic Psychology*, Vol. 12, No. 2 (fall) pp 61-73

Smith, M.R. (1991), The Loss of Neocortical Function: Subcortical Mediation of Memory and Habit Formation; *Proceedings of the 8<sup>th</sup> International Conference – International Society for the Study of Dissociation* of Chicago

Smith, M.R. and Jones, E.T. (1993), Neophobia, Ontological Insecurity, and Existential Choice Following Trauma; *Journal of Humanistic Psychology*; volume 33; number 4 (Fall); pp 89-109

Smith, M.R. (2005), Marjorie Toomim – A Rememberance; *Biofeedback*; number 33 (2); pp 77 –78

Sullivan, H.S. (1956), Schizophrenia, Paranoid States, and Related Conditions (Chapter 14) in Clinical Studies in Psychiatry; edited by Helen S. Perry, M. Gawel and M. Gibbon; Norton, NY

“Six Essential Therapeutic Tasks” (optional)  
available at: [responsesidetherapy.com](http://responsesidetherapy.com)

## **Technical Insert: Please Don't Read**

Answering the Unasked Question – “How many strikes did it take to produce the trauma divided self?” (The Tangibility Quotient)

### Markers of Progress/Completion:

- Absence of chronic inhibited (incomplete) nociceptive signal generation, transmission, registration
- De-escalation of tension, pressure, pain spiral (step down amygdala)
- Disinhibited nervous system (trauma blocks removed)
- Uninhibited motor expression/exhibition (moving in space [outside], walking and talking; moving in place [inside], breathing and beating your heart)
- The nucleus accumbens no longer rewards amnesia and numbing (“learned” instincts)

### TPPFC = D = G.A.T.A.S. (following Selye, 1980)

Tension, Pressure, **Pain**, Fear, Confusion = **Dope** = General Adaptation, Trauma Accommodation Syndrome

It's your habit to break

**Note:** addiction “pleasure” masks primal pain. Retreat and liberation are not the same thing. **Hint:** to “unhook” pinpoint the pain production (and make the intervention right there). Don't force your drugstore to go global. You don't want to pass out while you're coming to (don't slip yourself a mickey)



## Staying Conscious, Sane and on Purpose in Making the Transition (service essentials)

“The purpose of ACA is three-fold: to shelter and support “newcomers” in confronting “denial”; to comfort those mourning their early loss of security, trust and love; and to teach the skills for re-parenting ourselves with gentleness, humor, love and respect.” Page 82 ACA Text

“We give service just by being present to support and encourage other members of the program as they make the transition from frightened adult children to whole human beings who are capable of acting with the spontaneity of a child and the wisdom of a mature adult. This central concept underlies and supports all forms of service.” Page 354 ACA Text

“They are, as well, ways to describe the manifestation of two therapeutic ideals: no excess tension in the body and a neutral reaction to symbolic associations and mental representations of trauma.” Page 622 ACA Text

“The goal is to reach a place where the madeines of trauma and the imagos of internal addiction no longer carry a sting.” Page 622 ACA Text

Basic Question for Committee and Service Board People: How do we support our members as they make the transition to wholeness themselves and as they support and encourage others in moving out of their prison of isolation, pain, fear and confusion (reunification of the trauma divided self and liberation from deception and denial – freedom from trauma bondage and trauma bonders)?

Note: With liberation the present will not have to be run through the filter of the past.

Specifying Your Trauma Reproductions: Components of family trauma transfer – these are: repetition of dialogue (self talk and self recrimination), re-creation of scenes (the symbolic movies in the mind) and situations (with real-time “stand-ins” - the “Replacements”) which together can be called “The Distractors”, the recapitulation of emotions (feels the same) through the reconstitution of the biochemistry (internal uppers, downers, pain-killers and thought regulators) and reconfiguration of the body (held the same way), all of which is called the process of traumatic reproduction (Freud/Ferenczi). The Complete Picture

Guiding Question for Specifying Your Reproductions: How many knots are in your head and how many knots are in your muscles?

The Unconsciousness Process  
(“Would anyone like another brownie?”)

Adhering to the Doctrine of Denial (dysfunctionalism)

Threat (of traumatic intrusion) = alarming re-presentation/re-registration of traumatic past, perceived/believed to be unprocessable (annihilatory overload/psycholeptic crisis/chaotic nonentity) → re-stimulation of trauma reproduction habit (“product” of the addict society’s customized trauma-tweaking of factory original) = repetition/retox/reinstatement of heterostatic, trauma adjusted status quo = knocked out, numb, and resubmitted to insanity (statistically normal in a “pathology of normalcy”).

Note: the degree of tension (and relaxation) is the key indicator in reciprocal inhibition (Wolpe’s idea that you can’t be tensed and relaxed at the same time [mutually excluding states of being]).

Precise, ongoing monitoring and measuring of the post-traumatic vigilance sequence – tensed, braced, guarded, armored (literally wearing your trauma reproduction “habit” [Reich’s character armor]), and it’s reversal back to relaxed and okay (re-cognized and re-sensitized), is both a life detecting and lie detecting process. The life detecting process → detecting, finding and freeing the vulnerable parts of the self hiding and sleeping (and now trapped) inside the suit of armor. The lie detecting (and refuting) process ~~DIS~~PROVING the lie that staying bottled up, braced and anesthetized is your best (or only) hope.

## Questions and Considerations (for recovery)

- Can the approach get the contracted, compressed trauma-locked self safely unlocked and back to open?
- Re-association of dissociated parts (a critical aspect of recovery) – trauma arrested parts of the self are caught in a non-resolution re-stim/doping loop waiting for a liberated part(s) of the self to come back and resolve the arrestment and then guide each unhooked part forward to join the conscious present self.

**Philosophical note: personal re-unification and reunion with the source of life itself (conscious contact) is the final synthesis in the Hegel dialectic.**

- Layered and compartmentalized – the architecture of the post traumatic defense system
- Disguises ignorance and denial don't work very well in keeping the elephants away because the elephants are in your head. You might as well acknowledge the thundering herd.
- Sense and sensibility (“All is sensation”)
  - Receive the raw report (unfiltered sense registration).
  - Accurate interpretation (endangering, non-endangering, could be endangering [keep an eye on it]).
  - Respond autonomously (to secure phylogenetic ontological security [actual present time security]; Basic Five adequacy) react agentically (to secure/maintain the “secure” ontogenetic insecurity of the addict society (dope and denial)).
  - Subtract out one up-pushing pain contribution sight subtract out an equal amount down-pushing repression/inhibition. Keep subtracting until there is zero excess tension in the body ignoring chronic/ongoing nociceptive signal generation for parts of the body that are tense, compressed, contracted, distressed, wounded and injured does not make for a stable state of basic wellbeing.
- An important question to ask about any particular neuropsychological research finding; is the research (about neural structure, dynamics and processes [perception, transmission, reception, decision making, behavior]) being employed to clarify/facilitate rational decision making, and effective, therapeutic caretaking/caregiving or to block, thwart and undermine facilitation, are not applied at all? To what end the research? Dope? No Dope? What good is it? Ensnared by the lie or moving to consciousness and okay.
- A not impossible choice: choose to be liberated from the lie (accept all of what was – “for-give” the past and everybody in it including yourself). Then choose to be securely and consciously present at your happy destination (of re-occupation, reunion and freedom from bondage).
- Final thought: “what Hamlet and Shakespear couldn't see” (the limitation of the anti-libidinal ego [envisioning peace in the present]); you can't shoot your way out of self-imprisonment.

Thumbnail “Bang”! (Getting Closer)  
Closed Fist To Open Palm Secret Decoder Ring  
An Integrated Approach To An Integrated Self

Making the transition by disobeying insanity -- no longer captive to the addict society's lie that dope is your best hope (reproduction).

References/Key Word Tie Ins:

- 1) “Service Allows Us To Trust Ourselves” – transition, Chapter 10, page 354, ACA Text.
- 2) “Six Essential Recovery Tasks” (Disobedience) – disobeying, “Deconstructing Insanity” schematic.
- 3) “The Essence of Conflict Addiction” – lie, “The Unconsciousness Process”.
- 4) “Completing The Circle (in the Cycle of Violence)”, first paragraph, - reproduction, “The Complete Picture”, schematic.

Regarding Schematicized Recovery Approach:

Don't dys-integrate the integrity of the schematics (pieces out of context) – you'll lose a lot.

5 Key Questions To Ask Concerning Any Recovery Approach, Process, Therapy:

- What happened?
- Where did it leave you?
- What can you do to get better (to make the nots and the knots go away)?
- How will you know when you're done?
- With both symbol based screenings/distracting repression (layered) and primals/reflexive non-symbolized (primitive) repression the salient question remains the same: “What is/are the specific target(s) (Androclesian) of sensory/motor blockades/inhibition. Where does it actually hurt (all the pain generation sites that cause Melzak and Casey's pain gates to close and muscles to spasm)?

The recovery process that's implicit in the Orange Book (Red and Yellow combined) is explicit in the manuals.

## **Late Edition**

“Bang”

**Primary Reproductions**: The bottom line trauma events (actual episode) pushing for recognition (mind) and re-entry (body). Their emergence out of the compartments and the threat of their delayed surge up through the cover/screening layers trigger (restimulate) the organized (habituated) re-suppression, re-tox maintenance reactions.

Carefully accessing, uncovering, and unhooking, the traumatic re-productions and safely completing the emergence/integration process (re-solution) is the purpose and goal of recovery.

### **Technical Underpinnings (optional reading)**

The human self-system has a central processing unit encased in bone (brain, spinal cord/skull, column) with wires hanging out of the CPU to receive reports on the system-wide state of affairs (okay, not okay) and feedback on how action decisions (or inaction decisions as the case may be) are working out (better, worse, no difference).

There are three levels of command and control available in the adult CPU – analytical, habituated, reflexive.

Dysfunctionalism is an endochemical addiction. Functionalism is a matter of withdrawing from conditioned reality avoidance and returning to a state of un-addicted consciousness (re-opened to experience or un-impeded state/action signal relays, coming and going, and un-impaired operation of the decision/action/evaluation/correction apparatus [all three of the command and control levels working together to maintain phylogenetic psychobiologically rational instinct-based ontological well being.

### **Recovery Condensed**

“Revealed” into consciousness, “resurrected” from the deadened. The past fully re-presented, openness and security fully restored (it is processable). Here now and okay.