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The Importance of Affective-Kinetic Realities in the Experience of Trauma and in Trauma Therapy

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Abstract

In keeping with its epistemic derivation from Greek, the Oxford English Dictionary defines trauma as "A wound, or external bodily injury in general." That definition has expanded and even shifted toward a more mental understanding of trauma, and correlatively toward "managing" those who are trauma-afflicted or teaching them to "cope" with what has happened, whether a matter of shock, for example, on hearing of the death of a loved one or being in a car accident, or a matter of stress in terms of an overwhelming work load. The literature may prescribe therapy, but therapeutic help beyond strictly mental psychological help is warranted. Indeed, whatever its particular nature, trauma is bodily felt, which means that trauma is experienced in ways that affect the whole person, not simply his/her mental condition. A Jungian perspective on the unity of mind and body vindicates this basic understanding of trauma. The perspective leads to a detailed consideration and analysis of the startle reflex as both a whole person response and a temporal microcosm of experienced trauma. As such, it suggests a form of therapy anchored in movements directly antithetical to those of the startle reflex, thus offering a basis not only for exploring why movement is therapeutic, but for initiating integral mind-body forms of therapy.

Keywords: Trauma therapy; Kinesthesia; Mind-body unity; Startle reflex; Dynamic congruency

Literature Review

In his perceptive exposition of "The Spiritual Problem of Man" [1-6], an essay first published in 1928 then revised and expanded in 1931, Jung calls attention to "the fascination which the psyche holds for modern man," observing that "The fascination of the psyche brings about a new self-appraisal, a reassessment of our fundamental human nature. We can hardly be surprised if this leads to a rediscovery of the body after its long subjection to the spirit—we are even tempted to say that the flesh is getting its own back" [6]. His comment on this state of affairs is exceptionally thought-provoking, particularly as an entrée to the lived through corporeal-kinetic tensions of trauma:

The body lays claim to equal recognition; it exerts the same fascination as the psyche. If we are still caught in the old idea of an antithesis between mind and matter, this state of affairs must seem like an unbearable contradiction. But if we can reconcile ourselves to the mysterious truth that the spirit is the life of the body seen from within, and the body the outward manifestation of the life of the spirit—the two being really one—then we can understand why the striving to transcend the present level of consciousness through acceptance of the unconscious must give the body its due, and why recognition of the body cannot tolerate a philosophy that denies it in the name of the spirit [6].

Jung points out and underscores the unity of mind and body in a variety of other contexts [7-10] for example, in the context of emotions, archetypes, the self, symbols, and so on, all of them running counter to the present fad of "embodying" as a way of unifying mind and body, a way that may well be described as a lexical band-aid covering over a still suppurating 300+year-old wound [11-20]. Given the elementally disturbing nature of trauma, the challenge of bringing a bodily awareness of trauma to consciousness may well be daunting: it requires recognition of, and concentration on the sensory modality of kinesthesia, a sensory modality common to persons whose professional lives center on the lived through qualitative dynamics of movement, but not common to persons outside such professions. It is not that non-dancers and non-gymnasts, for example, are unconscious of their bodies' movement, but that they are not kinesthetically attuned to listening to its dynamics, i.e., kinesthetically attuned in a focal way to the temporal, spatial, and force aspects of movement. Neurophysiologist Marc Jeannerod's conclusion following his extensive experiments on moving subjects, namely, that "There are no reliable methods for suppressing kinesthetic information arising during the execution of a movement," speaks reams about the ongoing reality and existential significance of kinesthesia [21]. Trauma may bring movement to a standstill as in shock or overwhelming grief, but it does not in any way block kinesthesia. Indeed, "Kinesthesia does not turn on with movement and off with posture [22,23]. If that were true, one would have no awareness of the beginning or end of any movement. Indeed, one would have no idea where any 'limb' was to begin with, much less where it was at the end, or even how, when, and where to begin or end, thus making the accomplishment of any task impossible" [22].

Trauma commonly involves what people call "stress," bodily tensions that perseverate. Jonathan Kent et al. remark cogently "on this fact in relation to trauma surgeons:" [3].

Stress is ubiquitous in medicine, and trauma surgeons in particular experience volatile conditions with frequent periods of high stress. Based on psychological models of stress, such as the Yerkes-Dodson curve, multidimensional anxiety theory, and the threat versus challenge hypothesis, further study on acute stress and performance in medicine should incorporate measurements of both cognitive anxiety and physiological arousal to improve our understanding of how these variables affect performance in high stakes medical care. As our understanding of the effects of stress on technical and nontechnical skill improves, so too does the importance of research into how to mitigate this stress. Future work should thoroughly quantify acute stress in trauma care, and characterize its effects on medical errors, patient outcomes, surgeon wellness, and surgical education. Tools developed by allied fields—in medicine, military, athletics, and beyond—should not be ignored.

While *quantification* may serve to illuminate aspects of acute stress, *qualification* of the lived through bodily experience of stress may provide ways of mitigating or even alleviating it, ways that differ from "management" and "coping." The difference lies in the fact that, as Jung affirms, giving the body its due by bringing bodily experience to consciousness is a recognition of mind-body unity, a basic fact of life that sheds light on the basic dynamic congruity of emotions and movement, hence on such experiences as "cognitive anxiety" and "physiological arousal" [24]. Consideration and detailed analysis of the startle reflex documents that dynamic congruity in real-life, real-time terms.

Startle reflex

The startle reflex is a pan-animate reflex, the bodily movements of which are recognizable across species. Such basic facts about the reflex were documented more than 75 years ago. Psychologists Carney Landis and William Hunt, affiliated respectively with the New York Psychiatric Institute and Hospital and with Connecticut College, observed and filmed the responses of an extraordinarily broad range of subjects to the unexpected sound of a pistol shot [5]. They filmed subjects from human infants to human adults, from nonhuman primates and other mammals to reptiles and amphibia, and from officers of the New York City Police Department to schizophrenics, manic-depressives, feebleminded persons, epileptics, and other afflicted hospitalized persons. Their research thus included not just normal humans, but pathologically disturbed humans and nonhuman animals. In their book *The Startle Pattern*, Landis and Hunt describe a basic movement pattern across all subjects: "a general bodily flexion which resembles a protective contraction or 'shrinking' of the individual" [5]. They furthermore describe the pattern in humans in detail: "blinking of the eyes, head movement forward, a characteristic facial expression, raising and drawing forward of the shoulders, abduction of the upper arms, bending of the elbows, pronation of the lower arms, flexion of the fingers, forward movement of the trunk, contraction of the abdomen, and bending of the knees" [5]. Moreover they note that "the response is very rapid and follows sudden, intense stimulation" and that the "basic reaction is not amenable to voluntary control, and is universal" [5]. They point out that four possible emotions are connected with startle: curiosity, fear, annoyance, and "overflow effects," the latter arising because "the primary response is not sufficient to resolve all the motor tensions aroused" [5]. Of particular interest too is their comparison of the English word 'startle' that captures the temporal suddenness of the movement—the individual who is startled jumps or starts—with the German word "*zusammenfahren*" the individual who shrinks or shrivels. While the suddenness of the reflex testifies to the possibility of imminent danger, the shriveling or shrinking testifies to possible harm and to a protective move against that possible harm. What is learned from Landis and Hunt's extensive research is that the startle reflex is a complex archetypal bodily response, a phylogenetic kinetic-affective animate reality generated automatically as a protective reaction to something jarring, out of the ordinary, unexpected, and possibly harmful.

As an immediate but not enduring bodily reaction to something sudden and possibly harmful, the startle reflex is a temporal microcosm of trauma. While trauma may be the result of a sudden event—a car crash, for example—trauma commonly persists. In effect, unlike the startle reflex, it continues to cause harm. The temporal difference notwithstanding, the startle reflex offers insights into trauma and its care. The insights can be readily set forth initially in relation to what the U.S. National Institute of Mental Health describes on its website as "Coping with traumatic events" [2]. To begin with, the website states, "A traumatic event is an incident that causes physical, emotional, spiritual, or psychological harm. The person experiencing the distressing event may feel threatened, anxious, or frightened as a result. In some cases, they may not know how to respond, or may be in denial about the effect such an event has had." The website then states that "natural disasters," "acts of violence," and "car crashes and other accidents are examples of a traumatic event." It notes that "Most people have intense responses immediately following, and often for several weeks or months after a traumatic event." It lists several possible responses—"Feeling anxious, sad, or angry"; "Trouble concentrating and sleeping"; "Continually thinking about what happened"—but adds that "For most people, these are normal and expected responses and generally lessen with time." However the website also notes that "In some cases, these responses continue for a longer period of time and interfere with everyday life," adding that if the responses "are interfering with daily life or are not getting better over time, it is important to seek professional help." The help suggested is anchored in psychological counseling of one sort or another [2].

What is missing throughout is the experiencing body, without which recognition all the itemized responses to trauma lack experiential anchorage. "Intense responses," such as "Feeling anxious, sad, or angry" move through the body and most commonly move the body to move, though they can also move the body to remain still as when frozen in disbelief or overpowering sadness. In any event, to leave the body behind, even in the pursuit of "mental health," is to ignore the affective-

kinetic realities of being a body, all the more so given Jeannerod's conclusion regarding kinesthesia.

The startle reflex provides a kinetic-affective template for possible body-anchored therapeutic responses to trauma, thus a model for other possible kinesthetically-based therapeutic responses. For example, the sudden, contractive, withdrawal movements of the body in startle may be initially contrasted with an attenuated, slow motion overhead stretching of arms that stretches the whole body upward. Slowing down the typical stretch on getting out of bed and staying focally attuned to the movement awakens one kinesthetically to the qualitative dynamics of movement. Moreover the all-at-once whole body startle reflex movement in contracting or shrinking contrasts with a sequentially upward rising body that expands, and in which wrists, elbows and fingers slowly extend rather than suddenly bending or flexing. In effect, energy or effort throughout is not intense but flows calmly upward as the entire body, rather than trunk moving forward and abdomen moving backward, extends upward. In short, the qualitative character of movement comes to the fore: the spatio-temporal-energic dynamic of movement is consciously experienced. So also the affective character of movement is consciously experienced: emotions and movement are dynamically congruent. As pointed out elsewhere, "how would we otherwise know how to feign courage, for example, when we are in fact trembling in our boots? How would we otherwise know how to restrain an impulse to strike someone—or to hug someone for that matter? The fact that we can feign and restrain the kinetic dynamics of our emotions readily validates the wholly natural dynamic relationship of emotions and movement" [25-27].

Conclusion

One may certainly ask why movement is therapeutic. The answer lies not only in releasing tensions, but precisely in experiencing the dynamic congruency of emotions and movement, and furthermore, in experiencing a sense of agency, in awakening a focal attention to kinesthesia, and in experiencing the unity of mind-body. For example, recognition of the dynamic congruency of emotions and movement is cognitively enriching, both in opening one to an awareness of one's typical reactive style and in awakening one to a sense of agency in the possibility of change. In short, one discovers therapeutic options in the treatment of trauma and new ways of being present to the challenges of trauma.

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