

The Somatic Narrative in the Treatment of Trauma: A Sensorimotor Psychotherapy Approach

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Sensorimotor Psychotherapy® Institute2018

Sensorimotor Psychotherapy®

Sensorimotor Psychotherapy, developed by Dr. Pat Ogden, provides a framework that integrates three realms of experience – **somatic, cognitive and emotional**. This body-oriented approach emphasizes the critical importance of the somatic dimension when trying **to reach memories that are encoded only as sensory fragments or physical patterns** that have developed over time in response to traumatic experience. By recognizing these physical manifestations, interventions can be formulated to **facilitate the development of new adaptive actions**.

Drawing on polyvagal theory, structural dissociation, attachment, affect regulation theory, and principles of interpersonal neurobiology, this model integrates the key concepts that bridge the brain and body of the patient.

The body is Important because:

- The individual ‘remembers’ past trauma through sensorimotor **reliving of non-verbal iterations of the historical traumatic event** (dysregulated arousal, emotions, defensive responses) **and through mysterious physical symptoms** that seem to have no organic basis.

Inaccessible to verbal recall, they typically **remain unintegrated and unaltered by the course of time** (Van der Kolk & Van der Hart, 1991) and lead to a variety of disruptive symptoms.

Implicit & Explicit Selves

➤ Explicit self: cognitive, autobiographical, declarative

➤ **Memories of the explicit self can be reflected upon**

➤ Memories are “verbally accessible.” (Brewin 2001)

➤ Implicit self: somatic, sensory, affective

➤ **Memories of the implicit self cannot be reflected upon.**

➤ Unconscious **right brain implicit self** = “a cohesive, active mental structure that continuously **appraises** life’s experiences and responds according to its scheme of interpretation.” (Schoore 2003)

➤ Implicit memories are “situationally accessible,” (Brewin, 2001)

Ogden et al, 2 2006



The Somatic Narrative of the Implicit Self

“.. .continuously anticipates the future and powerfully determines behavior and intersubjectivity.

...the somatic narrative tells the story of past trauma and early attachment relationships.

Even what we read in facial expression is influenced by the somatic narrative.”

Ogden, 2016

Ways of Telling Our Story

“The quality of our relationships & our sense of self (in general & in any giving moment) is determined both by the story we tell ourselves verbally & by the story we tell ourselves nonverbally through physical patterns.”

Ogden 2012;2013

The past is “remembered as a series of unconscious expectations”

(Cortina and Liotti, 2007, p. 205).

Look at how the body reflects and
pertains to the presenting problem.

Procedural Learning: Expectations of the Future

Ogden et al 2006

- Most human behavior is driven by procedural memory —memory for process and function.

Procedural memory is implicit memory based on function: skills (riding a bike); conditioned learning: simple stimulus-response pairing; patterns learned and acquired over time; **ANS patterns of response, automatic behaviors and physical habits (slumped posture, tucked tail)** affective biases, and cognitive schemas.

How Procedural Learning Gets Encoded

➤ Early interaction patterns are represented pre-symbolically, through the **procedural organization of action sequences...**

➤ Infants form **expectancies** of how these interactions go, whether they are positive or negative, and these experiences are a trajectory for **development** (which can nevertheless transform). B. Beebe 2005

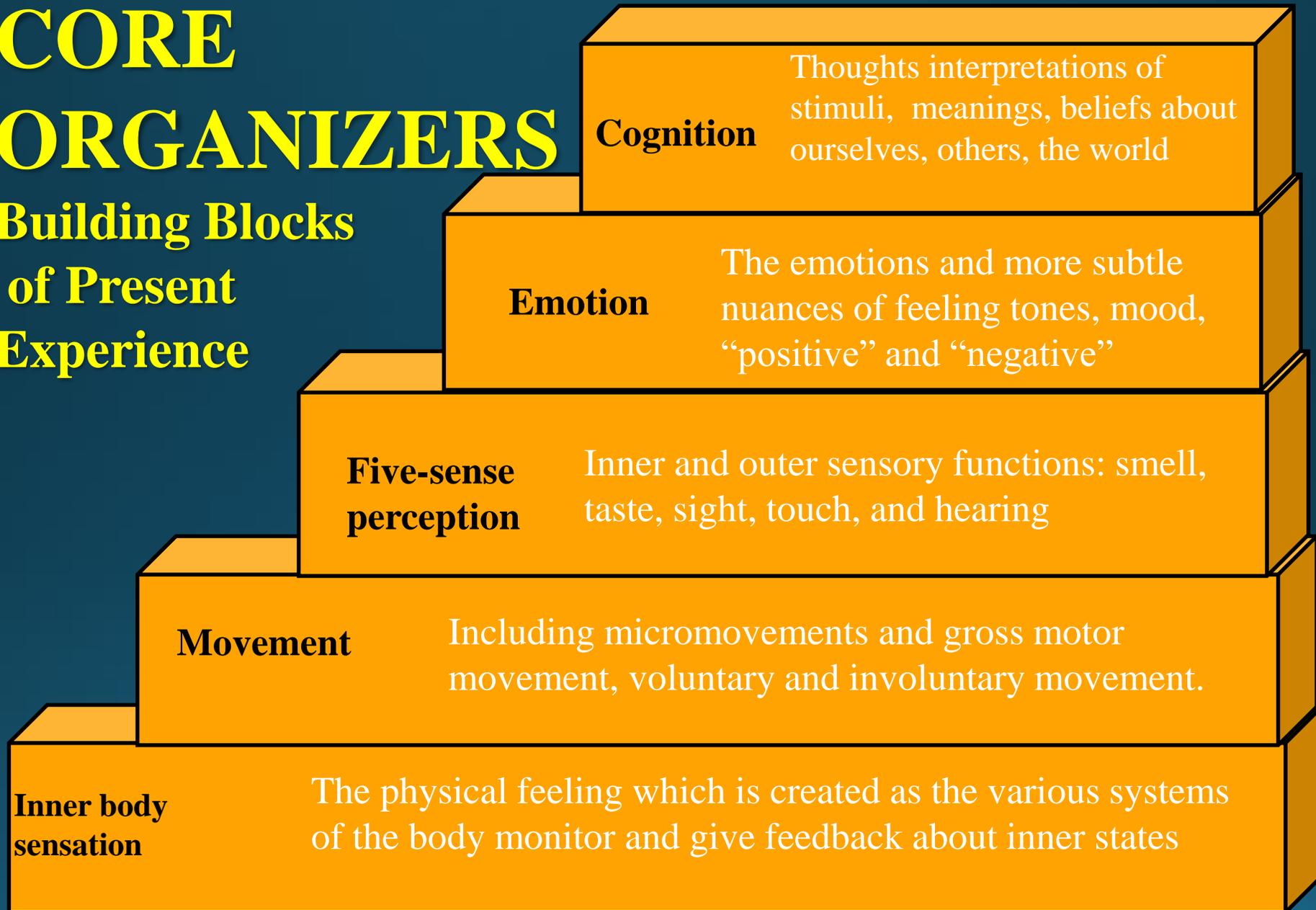
Organization of Experience

Kurtz 1990; Ogden 2007

- Our perception of experience is not random, but rather, we are **continually selecting and organizing experience**.
- Two processes determine how we organize experience: **the events that happen and the habits that convert these events into information, meaning, feeling and action**.
- The way we organize input reflects our previous adaptation to past experience (procedural learning)
- Change happens through **discovering how a client organizes experience and changing how she, he, they organize experience, not (only) through insight and analysis**.

CORE ORGANIZERS

Building Blocks of Present Experience



We can address “procedural learning” in two ways:

1. ”The first [type of therapeutic challenge] is to ...**observe, rather than interpret**, what takes place, and repeatedly call attention to it. This in itself tends to disrupt the automaticity with which procedural learning ordinarily is expressed.”
2. ”The second therapeutic tactic is to engage in activities that **directly disrupt** what has been procedurally learned” and thereby create the opportunity for new experiences

Grigsby & Stevens, p. 325

Therapeutic Bottom Up Processing

Instead of talking about experiences



One learns to observe & describe experience in simple words

We teach the client to notice the habitual movements, postures, or inner body sensation as these unfold in the moment

Instead of interpreting Experience



One is taught to be curious about experience

We teach the client to study the interaction of emotions, thoughts, inner body sensation and movement; to inhibit habitual trauma-related procedural action tendencies and execute new physical actions, somatic resources, adaptive defensive responses, self-regulatory skills.

Bodyreading: Reading the body for chronic patterns.

Tracking: Noticing the moment-to-moment changes in non-verbal phenomena.

Ogden et al 2006

“Directed Mindfulness”

Ogden 2007/2009

“Directed mindfulness” (Ogden 2009): paying attention to particular elements of internal experience (body sensation, movement, emotion, image, cognition) considered important to therapeutic goals.

Directed Mindfulness is essential in working with dysregulated patients. “General” mindfulness can increase dysregulation.

Embedded Relational Mindfulness™

Mindfulness is not taught or experienced through structured exercises or solitary practices, but is **integrated with and embedded within what transpires moment-to-moment between therapist and patient** in an attachment-focused therapy.

Privileges **mindful awareness of present moment experience of Core Organizers over “talking about,”** conversation, and interpretation.

Ogden 2015

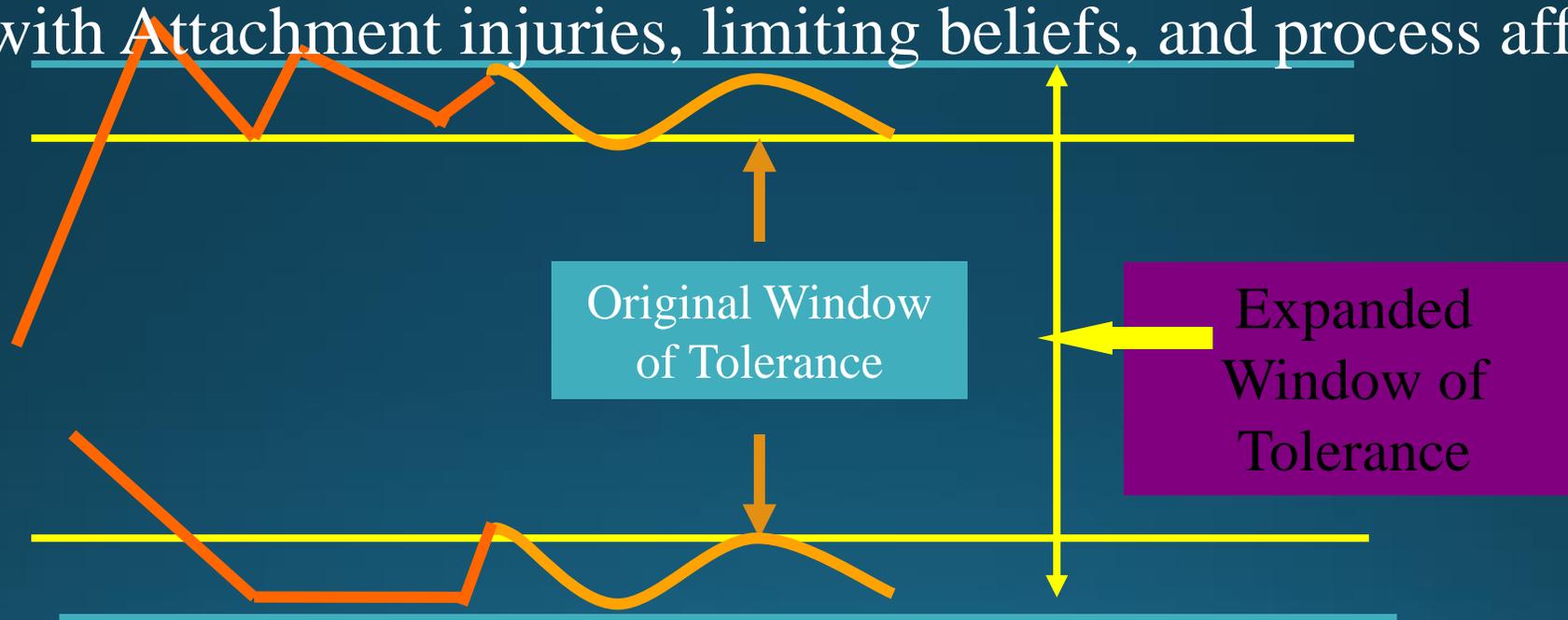
Guiding Principle: Expand the Window of Tolerance Increase Integrative Capacity

Ogden 2010

Phase I: Find resources that modulate arousal, and expand the window of tolerance

Phase II: Process the Traumatic Memory via sensorimotor level of processing

Phase III: Work with Attachment injuries, limiting beliefs, and process affect



Focus: Regulate Dysregulated Arousal

Ogden 2008

Regulated
arousal

Hyperarousal: activation exceeds
capacity to integrate



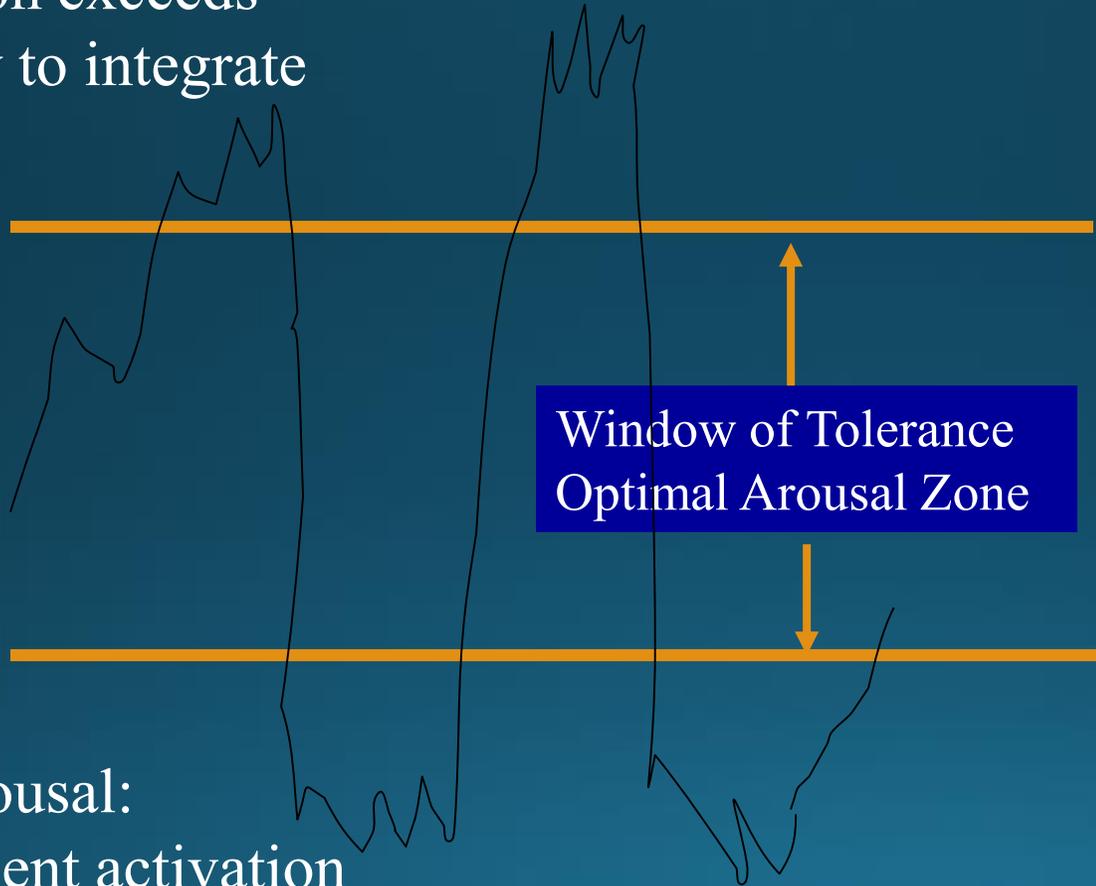
Dysregulated
arousal (beyond
the edges of the
window)

**Window of
Tolerance**

Hypoarousal: insufficient
activation to integrate

Somatic Resources for the Window of Tolerance

Hyperarousal:
activation exceeds
capacity to integrate



Hypoarousal:
insufficient activation
to integrate

Awareness of Body
Sensation

Grounding

Orienting

Boundaries

Locomotion

Breath

Containment

Self-Soothing

Movement

Reaching

Alignment

Centering

Ogden (2000)

Vocabulary for Sensorimotor Experience

(Ogden, 1999)

twitch

dull

sharp

achy

pounding

airy

suffocating

tremble

shivery

chills

vibration

itchy

stringy

fluid

frozen

warm

radiating

shudder

numb

flaccid

blocked

goose-bump

congested

heavy

tight

puffy

bubbly

tingly

shaky

paralyzed

sweaty

moist

clammy

jumbly

jerky

energized

stringy

damp

electric

tight skin

light

fuzzy

dense

cool

throbbing

Faint

quivery

pulsing

bloated

flushed

prickly

buzzy

flutter

pressure

jumpy

tense

wobbly

tingly

nauseous

spinning

dizzy

tremulous

Breathless

quake

Experiments Replace Suggestions

Ogden, 1999

Sometimes, tracking, contacting and the use of directed mindfulness spontaneously lead to transformation of a habitual pattern.

But we can also challenge repetitive responses by conducting thoughtful “experiments” that might gather new information or offer new options.

Experiments are conducted with openness and curiosity, without investment in a particular outcome, making "right" and "wrong" answers irrelevant.

Neuroception

How We Differentiate Friend from Foe

Porges, 2004

Autonomic Nervous System

Using “neuroception” (via neural circuits that sense or detect danger), we instinctively evaluate dangers and employ the most adaptive defensive responses



Safety: Ventral vagal system facilitates eye contact, vocalization, facial expression, vocalization to engage others

Social engagement system



Danger: Sympathetic arousal initiates active defenses of cry for help, flight, fight, or other self-protective action

Mobilizing defenses

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Life Threat: Dorsal Vagal activation facilitates defensive strategy of total submission, feigned death

Immobilizing defenses

Social Engagement System

Ventral Vagal Complex: the neural foundation for attachment (and other daily-life action systems)

facial muscles, larynx, middle ear; communication

Mobilizing Defenses: Increased SNS

Attachment Cry: voice, movement toward safe person

Flight: legs; movement away from source of threat

Fight: arms, shoulders; tightening jaw; movement toward the threat; aggressive action

Immobilizing Defense: Increased SNS

Freeze: stiffening; shallow, fast breathing, tense muscles

Immobilizing Defense: Increased Dorsal Vagal Tone

“Feigned death”: ‘submission;’ collapsed posture, limp, flaccid muscles

Ogden 2003 Adapted from Porges

Preparatory Movements

Ogden, 2003

- Preparatory movements are the **small micro-movements** that occur when there is a movement intention: running away, fighting, overt orienting, reaching out, etc.
- Encourage clients to **complete these movements through sequencing**, that is, to let the movement happen “by itself” without trying to “make” it happen, **or through voluntary execution.**
- In therapy, we look for **signs of orienting and defensive preparatory movements** and encourage their completion
- **Indicators** that preparatory movements need completion include: the “wanting” or “longing” to do something, small movements that precede the execution of defense or orienting response, and certain core organizers.



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