Encounters with the body
reflections on the integration of trauma theory and research into short term therapy

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- Currently works as a GP counsellor
- Private practice in Wellington, Shropshire.
- Previously bereavement counsellor and as a workplace counsellor in an NHS setting.
Sensorimotor psychotherapy

Sensorimotor Psychotherapy is a body-oriented talking therapy developed in the 1980’s by Pat Ogden, Ph.D.

And enriched by contributions from the work of Alan Schore, Bessel Van der Kolk, Daniel Siegel and Ellert Nijehuis.

Sensorimotor acknowledgement that the body holds its own memory of the trauma.
Health warning

Take care of yourself

Statistics show that probably at least some of you will relate to some of the material.
• When we acknowledge our inner and bodily wisdom we can then recognise our inherent capacity for healing  
  (Northrup 1998 in Etherington 2003 p33)

• Transformation does not depend upon memories  
  (Levine 1997 p204 in waking the tiger)

• Trauma survivors have symptoms instead of memories'  
  (Harvey 1990)

• “The most direct way to effect change is by working with the procedural learning system, rather than with declarative memories”  
  (Grigsby & Stevens, 2000)
Because of some of the questions following the DID/DSM talk yesterday I have taken out some of the reflections and added in some information I think you helpful.

In my practice I have an aversion to ‘Labels’

Therefore my purpose in therapy is not to provide a diagnosis or stick labels on people but to help them gain compassion for themselves and enable them to offer the core conditions to themselves.

If they only move the equivalent of half a degree on a compass, they will end up at a different destination.

I was interested in Maggie's comment on Friday night about ‘giving power back to the client’. I think that sensorimotor psychotherapy provides one way to do that.
Key concepts

Work in present
  • Notice
  • Curiosity
  • Experiment

Keep client in window of tolerance

Grounding
  • Breath,
  • Track body sensation, tension & temperature,
  • orientate, move head to help counter fixation and frozen state
  • counting, list items in room,

Leads to clients being able to:-
  • Offer core conditions to themselves
  • develop some compassion for themselves
  • Become more accepting of themselves
We cannot define ‘trauma’ simply in terms of event magnitude.

The reality is that it can be defined as ANYTHING that is overwhelming.
**Event and Developmental**
Because children are vulnerable and physically dependent on caretakers for survival, their thresholds for ‘trauma’ are different.  

Fisher 2009

“psychological trauma is the unique individual experience or an event, or a series of events or a set of enduring conditions, in which:

- The individual's ability to integrate his or her emotional experience is overwhelmed

Or

- The individual experiences (subjectively) a treat to life, bodily integrity or sanity”  
Saakvitne et al, 2000
We remember Trauma in our bodies because it helps us respond quicker next time we are in danger...

...........we do not have to think
I would suspect a body trigger is the culprit

If clients say:- things like

I just find myself doing it .... (loose my temper, act childishly, fight, panic) then I am so ashamed and do not know why I did it.

I just cannot maintain normal life.. I keep doing things that are not like me.

I have no energy

I don’t like myself

Issues with food, drink, self harm or neglect
Phase-oriented Treatment approach based on Pierre Janet (1898)

later adapted by Judith Herman and Onno van der Hart and Ellert Nijenhuis.

- **Phase 1**: Symptom reduction and stabilization
- **Phase 2**: Treatment of traumatic memory
  
  (try to only work with slithers of memory)
- **Phase 3**: Personality integration
  
  (survivor not victim)
Re-framing life threatening reality

The clients perceived reality

I feel threatened

Therefore I am in danger

Actual reality

is this actually life threatening?
The human brain

**Frontal cortex**

- Prefrontal cortex - thought perceptions and memory storage, impulse control
- Neo-cortex – abstract thinking
- Sub-cortex – problem solving
- Broca’s area – expressive language
- Wernicke’s area – receptive language centre

**Limbic**

- Hypothalamus, hippocampus, pituitary gland, amygdala

**Reptilian/ sensorimotor brain**

- Thalamus, cerebellum, Brain stem, spinal cord

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Top down / Bottom up
Reptilian Brain

- Heart rate
- Breathing
- Automatic startle
- Suck
- Fight
- Flight
- Flight
- Flight
- Freeze
- Non-verbal -
- Runs procedural learning
Learning to drive a car
Symptom reduction and stabilization

Aim to Overcome Deregulation:

to create a safe and stable life in the here and now

(adapted from Herman (1992))
Safety and Stabilization

- **Body safety**
  - Reducing/stoping self harm
- **Safe environment**
  - Living non-abusive, relationship, support
- **Emotional stability**
  - Ability to calm the body
  - Regulate impulses,
  - Self soothe,
  - Set boundaries
  - Manage symptoms triggered by mundane events.

adapted from Herman (1992)
Mirror neurons (Gallese, 2000)

Anticipate actions, empathy,

Help to track the body in the safety of the therapy room.

Important for counsellor safely too

Right brain/right brain (Schore)
Breath
Human beings utilize two modes of self-regulation (from Allan Schore)

Interactive regulation: The ability to utilize relationships to mitigate breaches in the window of tolerance and to either stimulate or calm oneself. Infants are dependent upon integrative regulation to survive, as well as develop.

Auto-regulation: The ability to self-regulate, independent of other people. It is the ability to calm oneself down when arousal rises to the upper limits of the window of tolerance or to stimulate oneself when arousal drops to the lower limits.

(Ogden 2002)
Attachment & developmental theory

- Research has demonstrated that it is not the traumatic events in our lives that determine resiliency so much as how we make sense of those events that determine our ability to experience resiliency (Siegel, 1999).

All the time you are working with the client you are continually trying to ground, and regulate them. The Therapist helps the client to notice activation and run experiments to explore self soothing actions eg hand on tummy and breathing

Try to help client to find their own unique ways
- to self soothe/auto regulate
- exploring resources they already have (what helped in the past)
- Experimenting to find new ones

- Watch for micro movements (but beware as hyper-vigilant client can find that threatening)

Take time to celebrate small achievements
All the time you are working with the client you are continually trying to ground, and regulate them.

- Exploring resources they already have (what helped in the past)
- Experimenting to find new ones
- Watch for micro movements (but beware as hyper-vigilant client can find that threatening)
“The primary therapeutic attitude [that needs to be] demonstrated [by the therapist or helper] is one of:

- P = playfulness
- A = acceptance
- C = curiosity
- E = empathy

Hughes, 2006
Often clients will not tell you all the symptoms they are sufferer but when you do the psycho-education they say

Oh I have a problem with that and that.......
"Trauma survivors have symptoms instead of memories"
(Harvey, 1990)

Adapted from Bremnmer & Marner, 1998

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Optimal arousal zone

Van der Kolk 1987

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Window of tolerance

Following trauma Siegel(1999)

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Symptoms of Un-Discharged Traumatic Stress

- Traumatic Event
- Stuck on "On"

- Depression, Flat affect
- Lethargy, Deadness
- Exhaustion, Chronic Fatigue
- Disorientation
- Disconnection, Dissociation
- Complex syndromes, Pain
- Low Blood Pressure
- Poor digestion

- Anxiety, Panic, Hyperactivity
- Exaggerated Startle
- Inability to relax, Restlessness
- Hyper-vigilance, Digestive problems
- Emotional flooding
- Chronic pain, Sleeplessness
- Hostility/rage

Normal Range
**Right hand brain**

- Thalamus
- Amygdala (smoke detector)

**Left Hand Brain**

- Pre-frontal cortex (Filling and storage)
- Hippocampus

- Broca’s
- Wernicke’s

**Hypothalamus**

- Fight
- Flight
- Feeding
- Reproduction
- Freeze
- Fart
- Flop

7 Fs (Norma Howes)
Treatment of traumatic memory

Hippocampus shrinks with lack of use. Brain scans show it can increase by 30% following counselling.

Reduce ‘live threat status’ by bringing into present.

Re frame events in present.
Dissociative Identity Disorder (DID)

- DID, formerly known as Multiple Personality Disorder

- Is a creative survival mechanism that allows children to overcome otherwise unendurable trauma. It is a sane response to very insane treatment.
Language of parts

- Dissociation may cause us to fragment our experiences in order to lessen their impact and help us survive (Etherington 2003 p32)

- Transformation does not depend upon memories (Levine 1997 p204) in waking the tiger
**Internal Family System** (Schwartz, 1995)

- **Exiles**
  - Disowned feelings, needs, hopes, memories

- **Self**
  - Curious, creative, confident, courageous, committed

- **Managers**
  - Suppress exiles, carry on with normal life

- **Fire Fighters**
  - Ensure exiles remain hidden
The language of parts: Structural dissociation

(Wise adult) carries on with normal life

Traumatised child self or selves

**Fight**
- Vigilance
- Angry
- Judgmental
- Destructive
- Mistrustful
- Controlling
- Suicidal
- Needs to control

**Flight**
- Escape
- Distancer
- Ambivalent
- Cannot commit
- Addictive or eating disordered

**Freeze**
- Fear
- Frozen
- Terrified
- Wary
- Phobic of being seen
- Reports panic attacks

**Submit**
- Shame
- Depressed
- Ashamed
- Self hatred
- Passive
- ‘good girl’
- Caretaker
- Self sacrificing

**Attach**
- Needy
- Desperate
- Craves
- Rescue
- Connection
- Sweet
- Innocent
- Wants someone to depend on

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(Van der Heart, Nijenhuis & Steele, 2006)
It does not work for everyone

It must be realized that accessing too much sensation too quickly, particularly before clients are able to observe their experience and put aside content and emotional states, may be counterproductive and may in fact increase dissociation and exacerbate PTSD symptoms.

Therefore therapists must proceed appropriately according to each client's pace and ability to integrate.

Nevertheless, an occasional client may remain unable or unwilling to work with sensorimotor processing, finding body sensations too overwhelming and distressing, or otherwise finding a somatic approach uninteresting or unappealing.

In such cases, sensorimotor processing is contraindicated and the therapist must use other techniques.
client work
In summary

Work in present
- Notice
- Curiosity
- Experiment

Grounding
- Breath,
- body sensation, tension & temperature,
- orientate, move head to help counter fixation and frozen state
- Counting, list items in room,

Offer psycho-education about trauma
- The role of the body
- Optimal VS non-optimal arousal (window of tolerance)
- triggering,
- Tracking Habitual responses (pulling back, pushing away, collapsing)
- post-traumatic, past and present confusion

(adapted from Fisher)
‘wake up’ the frontal lobes; Keep logic on line
- increase curiosity,
- develop mindfulness,
- challenge old interpretations,
- help patient dis-identity from symptoms

Teach ‘top-down management’ skills
- Cognitive-behavioural and coping skills

Use positive re-framing
- To decrease shame and increase curiosity:
  - focus on and develop survival resources

Leads to clients being able to
- Offer core conditions to themselves
- develop some compassion for themselves
- Become more accepting of themselves

(adapted from Fisher)
Thank you